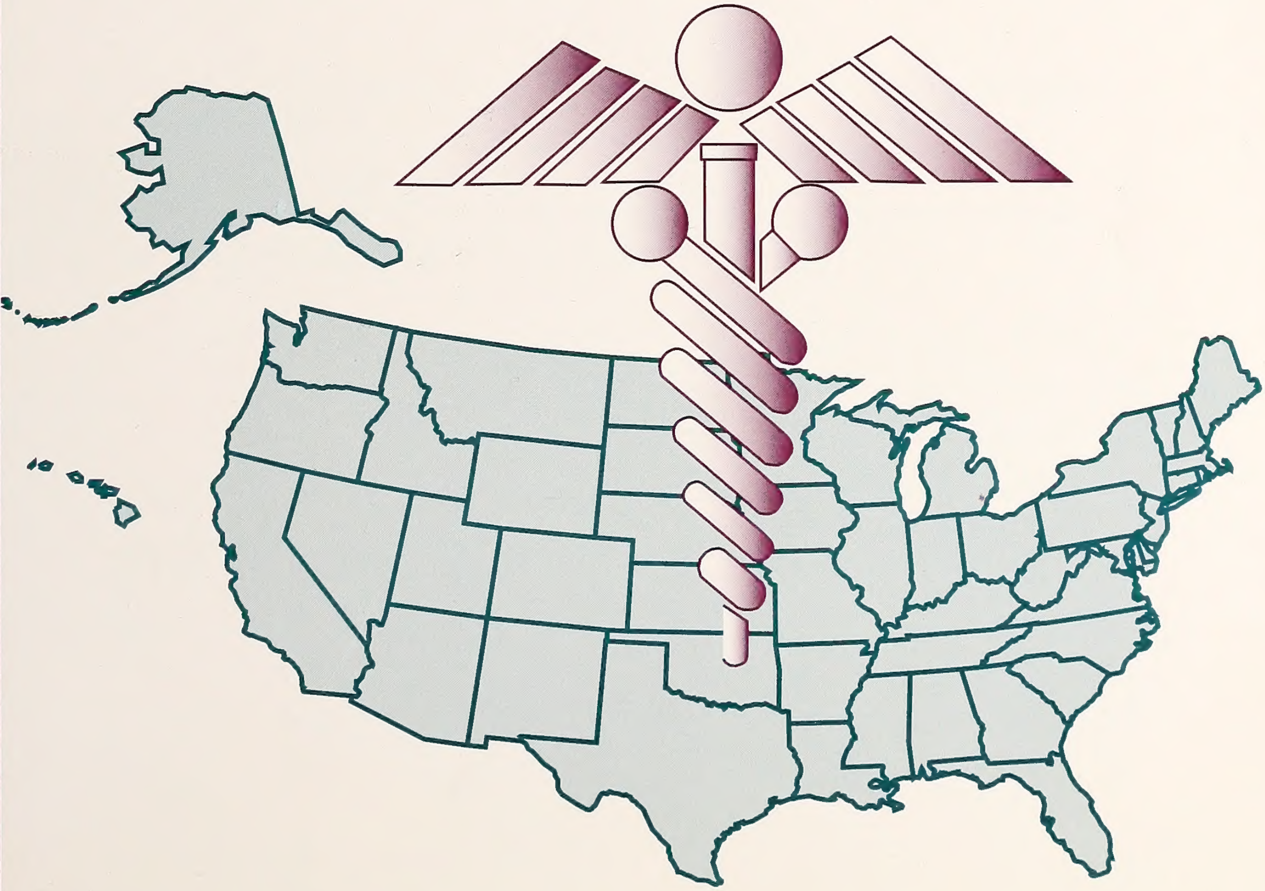
2003

NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS

PROGRAM DESCRIPTIONS AS OF JUNE 30, 2003



Centers for Medicare & Medicaid Services

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2003 NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS

PROGRAM DESCRIPTIONS AS OF JUNE 30, 2003

The National Summary of State Medicaid Managed Care Programs is composed annually by the Finance, Systems, and Budget Group (FSBG) of the Centers for Medicare & Medicaid Services (CMS). The descriptions of the States' Medicaid managed care programs as of June 30, 2003 were collected from State Medicaid Agencies and CMS Regional offices, an submitted for review to FSBG, Family and Children's Health Program Group (FCHPG), and Disabled and Elderly Health Program Group (DEHPG). The National Summary is divided into sections according to the program's "Operating Authority".

Special thanks to Loan Swisher, Joe del Pilar, and Carolyn Lawson of FSBG and Mike Fiore of FCHPG.

NOTE: An (*) asterisk next to the State's Medicaid Program indicates the Program is a "Non-Managed Care Waiver".

Donated for your reference by:
CHILDREN &ADULTS HEALTH PROGRAMS GROUP
Jennifer Ryan, Director
06-05-2013

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ALABAMA

Patient 1st

CONTACT INFORMATION

State Medicaid Contact:	Kay Hassett Alabama Medicaid Agency (334) 242-5019
State Website Address:	http://www.medicaid.state.al.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1997

Implementation Date:
January 01, 1997

Waiver Expiration Date:
February 18, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Mental Health, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Physician Assistants
-Nurse Practitioners

Enrollment

ALABAMA
Patient 1st

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- -Medicare Dual Eligible
- -Poverty Level Pregnant Woman
- -Reside in Nursing Facility or ICF/MR
- -Participate in HCBS Waiver
- -Long Term Care

Populations Mandatorily Enrolled:
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations
- -TITLE XXI SCHIP
- -Refugee and SOBRA

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- -Reviews complaints and grievances to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Aging Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Patient 1st

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
- -Enrollee Hotlines
- -Provider Data

Consumer Self-Report Data
None

Use of Collected Data:
- -Program Evaluation
- -Track Health Service provision

ARKANSAS
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Roy Jeffus
Medicaid Agency
(501) 682-8740

State Website Address:

http://www.medicaid.state.ar.us

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
December 04, 1997

Implementation Date:
March 01, 1998

Waiver Expiration Date:
November 21, 2005

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Full Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Pregnant women, Infants, Children (SOBRA)
-Childen with Special Needs

Subpopulations Excluded from Otherwise Included Populations:
- -Reside in Nursing Facility or ICF/MR
- -QMB
- -Special low income beneficiaries
- -Qualified individuals 1 and 2
- -ARKids First-B
- -Women Health (FP)
- -Eligibility only Retroactive
- -Tuberculosis
- -1115 demonstration waivers
- -Medicare Dual Eligible

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Not Applicable

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

The state contracts with transportation brokers on a capitation basis.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -Field Audits
- -MCO/PIHP/PAHP Standards (see below for details)
- -Monitoring of MCO/PIHP/PAHP Standards
- -On-Site Reviews
- -Provider Data

Use of Collected Data
- -Contract Standard Compliance
- -Monitor Quality Improvement
- -Plan Reimbursement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal

Consumer Self-Report Data
-State-developed Survey

Use of HEDIS
- -The State DOES NOT use any of the HEDIS measures
- -The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements
- -Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
- -Standards to ensure complete, accurate, timely encounter

Collections: Submission Specifications
None

data submission

Collection: Standardized Forms
None

Validation: Methods
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Provider ID
-Type of Service
-Medicaid Eligibility

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PIHP/PAHP Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Arkansas Foundation for Medical Care

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Administration or validation of consumer or provider surveys

ARKANSAS

Primary Care Physician

CONTACT INFORMATION

State Medicaid Contact:

Roy Jeffus
State Medicaid Agency
(501) 682-1671

State Website Address: http://www.medicaid.state.ar.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 30, 1996

Implementation Date:
November 01, 1996

Waiver Expiration Date:
December 17, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT(25 counties), Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Physician, Podiatry, X-Ray

Allowable PCPs:
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Area Health Education Centers (AHECs)
-Pediatricians
-General Practitioners
-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-1115 Demonstration Waiver (Our Kids B)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Eligibility Period that is Retroactive
-Medically Needy "Spenddown" Categories

Lock-In Provision:

6 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Connect Care

ADDITIONAL INFORMATION

All included services requires PCP referral. All other services available in Medicaid FFS do not require PCP referral.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Enrollee Hotlines
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Beneficiary Provider Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Track Health Service provision

Consumer Self-Report Data

None

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

-Number of children with diagnosis of rubella(measles)/1,000 children
-Percentage of low birth weight infants

ARKANSAS
Primary Care Physician

Access/Availability of Care
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Inpatient admissions/1,000 beneficiaries

Provider Characteristics
None

Beneficiary Characteristics
None

CALIFORNIA
Caloptima

CONTACT INFORMATION

State Medicaid Contact:	Luis Rico Medi-Cal Managed Care Division (916) 449-5000
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 01, 1995

Implementation Date:
October 01, 1995

Waiver Expiration Date:
July 10, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Long Term Care, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Nurse Practitioners
-Federally Qualified Health Centers (FQHCs)
-Nurse Midwives
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

CALIFORNIA
Caloptima

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Caloptima

ADDITIONAL INFORMATION

1 of 5 County Organized Health Systems that has special waiver authority under OBRA 1985.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid

that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms
None

Validation: Methods
None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Check-ups after delivery
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

Standards/Accreditation

CALIFORNIA

Caloptima

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-State was not under contract with an EQRO at the time of the data collection.

Accreditation Required for Participation
None

EQRO Name
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
-Not Applicable

CALIFORNIA
Central Coast Alliance for Health

CONTACT INFORMATION

State Medicaid Contact:

Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1996

Implementation Date:
January 01, 1996

Waiver Expiration Date:
July 10, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-OBRA 1985 & 1990

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(ii)and(vi)

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

Included Services:
Case Management, Developmental, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants

Enrollment

CALIFORNIA
Central Coast Alliance for Health

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-All Categories of Federally Eligible Medi-Cal Beneficiaries

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Central Coast Alliance For Health

ADDITIONAL INFORMATION

1 of 5 County Organized Health Systems that has special waiver authority under OBRA 1985.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the

HEDIS measures listed for Medicaid in the future
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms
None

Validation: Methods
None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Check-ups after delivery
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-State was not under contract with an EQRO at the time of the data collection.

Accreditation Required for Participation
None

EQRO Name
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
-Not Applicable

CALIFORNIA
Health Plan of San Mateo

CONTACT INFORMATION

State Medicaid Contact:

Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 30, 1987

Implementation Date:
November 30, 1987

Waiver Expiration Date:
August 26, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-OBRA 1985 & 1990-1903(m)(2)(A)(ii)and(vi)

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists
-Nurse Midwives
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in ICF/MR

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligiblity and claims data to identify members of these groups,
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Plan of San Mateo

ADDITIONAL INFORMATION

1 of 5 County Health Systems that has special waiver authority under OBRA 1985.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

CALIFORNIA
Health Plan of San Mateo

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms
None

Validation: Methods
None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Adolescent Well-Care Visit rates
-Asthma care - medication use
-Check-ups after delivery
-Childhood Immunizations
-Eye exam for Diabetics
-Initiation of prenatal care - timeliness of

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)

Non-Clinical Topics
-Improving the Quality of Pediatric Data
-Initial Health Assessments

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation Required for Participation
None

CALIFORNIA

Health Plan of San Mateo

Accreditation for Deeming
None

EQRO Organization
-State was not under contract with an EQRO at the time of the data collection.

EQRO Name
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
-Not Applicable

CALIFORNIA

Hudman

CONTACT INFORMATION

State Medicaid Contact:	Benjamin C. Thomas Medi-Cal Operations Division (916) 552-9115
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 24, 1992

Implementation Date:
April 24, 1992

Waiver Expiration Date:
October 14, 2003

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

This waiver is a mechanism for placement in freestanding nursing facilities rather than hospital based distinct part nursing facilities unless waiver exemptions allow residents to remain in distinct part nursing facilities.

CALIFORNIA
Managed Care Network

CONTACT INFORMATION

State Medicaid Contact:	Luis Rico Medi-Cal Managed Care Division (916) 449-5000
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 28, 1997

Implementation Date:
March 01, 1997

Waiver Expiration Date:
June 30, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, EPSDT, Family Planning, Health Education and Preventive, Home Health, Immunization, Laboratory, Outpatient Hospital, Physician, Transportation, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers
-Physical Medicine/Rehabilitation Physicians
-Primary Care Clinics
-Community Clinics
-Hospital Outpatient Clinics
-County Government Clinics
-Health Maintenance Organizations
-Specialty Physicians
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Reside in Nursing Facility or ICF/MR
-Other Insurance

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-County Medical Services Program Eligibles

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Placer County Managed Care Network

Sonoma County Partners for Health Managed Care Network

ADDITIONAL INFORMATION

None

CALIFORNIA
Medi-Cal Mental Health Care Field Test (San Mateo County)

CONTACT INFORMATION

State Medicaid Contact:	Rita McCabe-Hax Mental Health (916) 654-5691
State Website Address:	http://www.dmh.cahwnet.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 13, 1995

Implementation Date:
April 01, 1995

Waiver Expiration Date:
July 25, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4)Methods of Administration

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Case Rate Funding Mechanism for Most Specialty Mental Health Services for Therapeu - Fee-for-Service

Service Delivery

Included Services:
Inpatient Mental Health, Outpatient Mental Health, Pharmacy, Pharmacy-related laboratory, Targeted Case Management

Contractor Types:
-County Operated Entity (Public)

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Other(State-Only Medi-Cal and Emergency Services Only

populations)
-Section 1931 (AFDC/TANF) Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Not Applicable

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Children with Special Health Care Needs by specific aid codes and by CCS program eligibility

Agencies with which Medicaid Coordinates the Operation of the Program:
-Department of Mental Health

ADDITIONAL INFORMATION

All Medicaid eligibles in San Mateo County are eligible for mental health services on an as needed basis. There is a case rate funding mechanism for all specialty mental health services except for pharmacy and related laboratory costs and therapeutic behavioral services.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Quality Improvement Council
-Written quality strategy reguired by 42 CFR 438, 202 under development

Consumer Self-Report Data
None

Use of Collected Data:
-ad hoc and annual reports

CALIFORNIA

Medi-Cal Specialty Mental Health Services Consolidation

CONTACT INFORMATION

State Medicaid Contact:

Rita McCabe-Hax
Mental Health
(916) 654-5691

State Website Address:

http://www.dmh.cahwnet.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 15, 1995

Implementation Date:
March 15, 1995

Waiver Expiration Date:
April 27, 2005

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) Method of Administration

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mechanism to allow Fee-for-Service payment for mental health services statewide. - Fee-for-Service

Service Delivery

Included Services:
Inpatient Mental Health, Outpatient Mental Health, Targeted Case Management

Contractor Types:
None

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Other (State-Only Medi-Cal and Emergency Services only

Subpopulations Excluded from Otherwise Included Populations:

-Not Applicable

populations)

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Children with special health care needs by specific aid codes and by CCS program eligiblity

Agencies with which Medicaid Coordinates the Operation of the Program:

-Department of Mental Health

ADDITIONAL INFORMATION

Plan not at risk for federal financial participation. All Medicaid eligibles are automatically enrolled. This program covers specialty mental health services. County mental health departments have first right of refusal to serve as the mental health plan. This program is not available in San Mateo and Solano counties. Although this program is, in effect, a statewide program, it has been implemented in smaller and defined geographic areas, while ensuring adequate access to quality services for all Medi-Cal beneficiaries.

CALIFORNIA
Partnership Health Plan of California

CONTACT INFORMATION

State Medicaid Contact:	Luis Rico Medi-Cal Managed Care Division (916) 449-5000
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 01, 1994

Implementation Date:
May 01, 1994

Waiver Expiration Date:
February 10, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-OBRA 1985 & 1990

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(ii) and (vi)

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health (Solano Co. only), Laboratory, Long Term Care - Counseling and Social Support, Outpatient Hospital, Outpatient Mental Health (Solano County only), Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Pediatricians
-General Practitioners

Enrollment

CALIFORNIA
Partnership Health Plan of California

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Participate in HCBS Waiver

Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Medi-Cal eligibles with a share of cost and Medically Needy
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Partnership Health Plan

ADDITIONAL INFORMATION

1 of 5 County Organized Health Systems that has special waiver authority under OBRA 1985. In Yolo County, a small Health Plan, Sutter Senoir Care, that serves a limited number of zip codes coexist in a county with a County Organized Health System.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA

specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms

Collection: Standardized Forms
None

Validation: Methods
None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Check-ups after delivery
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-State was not under contract with an EQRO at the time of the data collection.

Accreditation Required for Participation
None

EQRO Name
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
-Not Applicable

CALIFORNIA
Primary Care Case Management Program

CONTACT INFORMATION

State Medicaid Contact:	Luis Rico Medi-Cal Managed Care Division (916) 449-5000
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
December 20, 1982

Implementation Date:
August 01, 1984

Waiver Expiration Date:
August 13, 2003

Sections of Title XIX Waived:
-1902(a)(30) Upper Payment Limit

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PAHP - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Laboratory, Long Term Care, Outpatient Hospital, Pharmacy, Physician, Specialty Mental Health, Transportation, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Pediatricians
-General Practitioners
-Nurse Practitioners
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

-Foster Care Children
-Other (All categories of federally eligible Medi-Cal beneficiaries)
-Section 1931 (AFDC/TANF) Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Period Less Than 3 Months
-Poverty Level Pregnant Woman
-Member approved for a Major Organ Transplant

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Plan is responsible to identify this group

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Positive Healthcare/AIDS Health Care

ADDITIONAL INFORMATION

PCPs contract to provide and assume risk for primary care, specialty physician services, and selected outpatient preventive and treatment services. The Program is designed for people living with AIDS.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Does Not Collect Quality Data

Use of Collected Data

-Not Applicable

Consumer Self-Report Data

None

Use of HEDIS

-Not Applicable

Standards/Accreditation

MCO/PIHP/PAHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Not Applicable

CALIFORNIA

Primary Care Case Management Program

EQRO Organization
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
None

CALIFORNIA
Sacramento Geographic Managed Care

CONTACT INFORMATION

State Medicaid Contact:	Luis Rico Medi-Cal Managed Care Division (916) 449-5000
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Health Care Options/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1994

Implementation Date:
April 01, 1994

Waiver Expiration Date:
October 08, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(5)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Enhanced Perinatal and Preventive, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Psychiatrists
-Pediatricians
-Family Practitioners
-Internists
-General Practitioners

CALIFORNIA
Sacramento Geographic Managed Care

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Adoption Assist/Medically Indigent-Child
-Foster Care/Medically Indigent-Child
-Pregnant/Medically Indigent-Adult
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver

Populations Mandatorily Enrolled:
-Section 1931 (CALWORKS/TANF) Children and Related Populations
-Special Program/Percent/Children
-Section 1931 (CALWORKS/TANF) Adults and Related Populations
-Public Assistance-Family

Lock-In Provision:
No lock-in

Dental PAHP - Full Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Dentists

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Adoption Assist/Medically indigent-Child
-Foster Care/Medically indigent-Child
-Pregnant/Medically Indigent-Adult

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver
-Other Insurance
-Enrolled In Another Medicaid Program

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Section 1931 (CALWORKS/TANF) Children and Related Populations
-Section 1931 (CALWORKS/TANF) Adults and Related Populations
-Public Assistance-Family
-Special Program/Percent/Children

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities
-Education Agency
-Home and Community Based Care
-Local Schools
-Maternal and Child Health Agency

- -Mental Health Agency
- -Public Health Agency
- -Social Services Agency
- -Substance Abuse Agency
- -Title V

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan-Sacramento GMC
Delta Dental Plan of California-Sacramento GMC
Kaiser Foundation-Sacramento GMC
Western Dental Services-Sacramento GMC
Blue Cross of California-Sacramento GMC
Health Net-Sacramento GMC
Molina Medical Centers-Sacramento GMC
Western Health Advantage-Sacramento GMC

ADDITIONAL INFORMATION

Restricts aid code beneficiaries designated mandatory to enroll in 1 of 5 health plans and 1 of 4 dental plans.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-CAHPS
  Adult Medicaid Questionnaire
  Child Medicaid Questionnaire

Use of Collected Data

-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Specifications for the submission of encounter data to the Medicaid agency

Collection: Standardized Forms

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-National Drug Code assigned by the Federal Drug Administration
-NSF - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing

Collections: Submission Specifications

-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range) data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Check-ups after delivery
-Frequency of on-going prenatal care
-Immunizations for two year olds

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Asthma management
-Breathe with ease (a comprehensive multi-disciplinary health management system for children with asthma)
-CHDP documentation
-Childhood Immunization
-Improving the quality of asthma care and reduction of inappropriate use of services through patient self-management
-Pediatric preventive services

Non-Clinical Topics
-Appropriateness of specialty referral and improving access to care
-Depression pharmacy management
-Improvement of 120-Day assessment compliance
-Improving timeliness of initial health assessments
-Interventions-What to do when your child gets sick
-Member satisfaction survey

Standards/Accreditation

CALIFORNIA
Sacramento Geographic Managed Care

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-State was not under contract with an EQRO at the time of data collection.

Accreditation Required for Participation
None

EQRO Name
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
-Not Applicable

CALIFORNIA
San Diego Geographic Managed Care

CONTACT INFORMATION

State Medicaid Contact:

Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Health Care Options/Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 17, 1998

Implementation Date:
October 17, 1998

Waiver Expiration Date:
October 10, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(5), 1902(a)(30)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Enhanced Perinatal and Preventive, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers

CALIFORNIA
San Diego Geographic Managed Care

Enrollment

Populations Voluntarily Enrolled:
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care
- Adoption Assist/Medically Indigent-Child
- Foster Care/Medically Indigent-Child
- Pregnant/Medically Indigent-Adult

Subpopulations Excluded from Otherwise Included Populations:
- Reside in Nursing Facility or ICF/MR
- Eligibility Period Less Than 3 Months
- Participate in HCBS Waiver
- Other Insurance
- Enrolled in Another Medicaid Program

Populations Mandatorily Enrolled:
- Section 1931 (CALWORKS TANF) Children and Related Populations
- Section 1931 (CALWORKS TANF) Adults and Related Populations
- Public Assistance-Family
- Special Program/Percent/Children

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups
- Uses other means to identify members of these groups - program linkage and/or family contact
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Developmental Disabililties
- Education Agency
- Home and Community Based Care
- Local Schools
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency
- Title V

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross of California-San Diego GMC
Health Net-San Diego GMC
Sharp Health Plan
Universal Care
Community Health Group
Kaiser Foundation-San Diego GMC
UCSD Health Plan
Universal Care San Diego GMC

ADDITIONAL INFORMATION

Restricts aid code beneficiaries designated as mandatory to enroll in 1 of 6 health plans.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)

Use of Collected Data
- Contract Standard Compliance

-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
-Adult and child English and Spanish
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-National Drug Code assigned by the Federal Drug Administration
-NSF - the CMS approved electronic file format for transmitting non-institutional and supplier billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
No

Performance Measures

Process Quality
-Check-ups after delivery
-Frequency of on-going prenatal care
-Immunizations for two year olds

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary

-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-State was not under contract with an EQRO at the time of the data Collection.

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
-Not Applicable

CALIFORNIA
Santa Barbara Health Initiative

CONTACT INFORMATION

State Medicaid Contact:

Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
September 01, 1983

Implementation Date:
September 01, 1983

Waiver Expiration Date:
January 11, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

HIO - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Health Education and Counseling, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers

Enrollment

CALIFORNIA
Santa Barbara Health Initiative

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-All Categories of Federally Eligible Medi-Cal Beneficiaries

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses other means to identify members of these groups - program linkage and/or family contact
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Pre-Natal Plus 2
Santa Barbara Regional Health Authority
Santa Barbara Health Initiative

ADDITIONAL INFORMATION

Established under State Statute of 1982.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Deadlines for regular/ongoing encounter data submission(s)

Collection: Standardized Forms
None

Validation: Methods
-None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Check-ups after delivery
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Childhood Immunization
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

CALIFORNIA
Santa Barbara Health Initiative

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-State was not under contract with an EQRO at the time of the data collection.

Accreditation Required for Participation
None

EQRO Name
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
-Not Applicable

CALIFORNIA

Selective Provider Contracting Program

CONTACT INFORMATION

State Medicaid Contact:

Benjamin C. Thomas
Medi-Cal Operations
(916) 552-9116

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Initial Waiver Approval Date:
September 21, 1982

Implementation Date:
September 21, 1982

Waiver Expiration Date:
December 31, 2004

Sections of Title XIX Waived:
-1902(a)(13)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(5)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

ADDITIONAL INFORMATION

This waiver allows CA to selectively contract with hospitals to provide acute inpatient care to all Medi-Cal beneficiaries. This waiver does not differentiate by beneficiary aid code.

CALIFORNIA

Two-Plan Model Program

CONTACT INFORMATION

State Medicaid Contact:	Luis Rico Medi-Cal Managed Care Division (916) 449-5000
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Health Care Options/Maximus

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 22, 1996

Implementation Date:
January 23, 1996

Waiver Expiration Date:
November 08, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Cultural/Linguistic, Durable Medical Equipment, EPSDT, Family Planning, Health Education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Preventive Health Screening, Transportation (when medically necessary), Vision, X-Ray

Allowable PCPs:
-Internists
-Family Practitioners
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Pediatricians
-General Practitioners

Enrollment

CALIFORNIA
Two-Plan Model Program

Populations Voluntarily Enrolled:
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
- Poverty Level Pregnant Woman
- Reside in Nursing Facility or ICF/MR
- Eligibility Period Less Than 3 Months
- Participate in HCBS Waiver

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups
- Uses other means to identify members of these groups - program linkage and/or family contact
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- California Childrens Services
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Alameda Alliance for Health
Contra Costa Health Plan
Health Plan of San Joaquin
Kern Family Health Care
Molina Medical Centers-TPMP
Santa Clara Family Health Plan
Blue Cross of California-TPMP
Health Net-TPMP
Inland Empire Health Plan
LA Care Health Plan
San Francisco Health Plan

ADDITIONAL INFORMATION

Eligibles may choose to join either a local initiative plan or a commercial plan selected by the State.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- Ombudsman
- On-site Reviews
- Performance Improvements Projects (see below for details)

Use of Collected Data
- Contract Standard Compliance
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

-Performance Measures (see below for details)

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements

-Specifications for the submission of encounter data to the Medicaid agency

Collection: Standardized Forms

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-National Drug Codes assigned by the Federal Drug Administration
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Collections: Submission Specifications

-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments

No

Performance Measures

Process Quality

-Check-ups after delivery
-Frequency of on-going prenatal care
-Immunizations for two year olds

Access/Availability of Care

None

Health Status/Outcomes Quality

None

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
None

Beneficiary Characteristics
None

Health Plan/ Provider Characteristics
None

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics

-Availability of language interpretation services

Clinical Topics

-Childhood Immunization
-Well Child Care/EPSDT

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-State was not under contract with an EQRO at the time of the data collection.

Accreditation Required for Participation
None

EQRO Name
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
-Not Applicable

COLORADO

Mental Health Capitation Program

CONTACT INFORMATION

State Medicaid Contact:

Katie Brookler
Mental Health Services
(303) 866-2416

State Website Address:

http://www.CHCPF.state.co.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
October 04, 1993

Implementation Date:
July 01, 1995

Waiver Expiration Date:
May 04, 2005

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Full Capitation

Service Delivery

Included Services:
Crisis, IMD, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential

Contractor Types:
-Behavioral Health MCO (Private)

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Behavioral Care
Jefferson Center for Mental Health
North Range Behavioral
SyCare-Options Colorado Health Networks
Behavioral Healthcare, Inc.
Mental Health Center of Boulder
Northeast Behavioral Health
West Slope-Options Colorado Health Networks

ADDITIONAL INFORMATION

Due to the nature of the waiver which is for a limited segment of services, the program does not designate a primary care provider. Individuals choose their own providers or rely on the contractor (Mental Health and Service Agency (MHASA)) for referral. The contractor acts as the gatekeeper.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-Mental Health Statistics Improvement Program (MHSIP)

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)

Collections: Submission Specifications

None

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data

Collection: Standardized Forms
None

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average wait time for an appointment with PCP

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Number of PCP visits per beneficiary

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Standards/Accreditation

MCO/PIHP/PAHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Mandatory Activities
-Validation of performance improvement projects

EQRO Optional Activities

None

CONNECTICUT
HUSKY A

CONTACT INFORMATION

State Medicaid Contact:	Ellen Tracy Department of Social Services (860) 424-5215
State Website Address:	http://www.huskyhealth.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
Affiliated Computer Systems

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 20, 1995

Implementation Date:
October 01, 1995

Waiver Expiration Date:
May 30, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Chiropractic, Clinics, Dental, Durable Medical Equipment, EPSDT, Family Planning, Federally Qualified Health Centers, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Intermediate Care Facilities, Laboratory, Nurse Practitioners, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Outreach, Pediatrics, Pharmacy, Physical Therapy, Physician, Podiatry, Pre-natal, Rural Health Clinics, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants

Enrollment

CONNECTICUT
HUSKY A

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver
- Children in Targeted Case Management under Department of Mental Health and Addiction Services
- Children in Targeted Case Management under Department of Mental Retardation
- Children in Katie Beckett Waiver

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Foster Care Children
- Pregnant Women

Lock-In Provision:
12 months lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of the Balanced Budget Act group.

Agencies with which Medicaid Coordinates the Operation of the Program:
- Child Welfare Agency
- Education Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem Blue Care Family Plan

FirstChoice Health Plan - Preferred One

ADDITIONAL INFORMATION

12 month Continuous Eligibility for children under 19 and the 6 month Guaranteed Eligibility for HUSKY Adults was eliminated from Connecticut Department of Social Services policy effective 4/1/2003. State decides which guaranteed eligibility is applicable based upon whether the enrollee is an adult or child.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PIHP/PAHP Standards (see below for details)
- Monitoring of MCO/PIHP/PAHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data
- Beneficiary Plan Selection
- Contract Standard Compliance
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

CONNECTICUT
HUSKY A

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-State conducts multiple critical edits to ensure data accuracy

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate

Health Status/Outcomes Quality
None

-Percentage of beneficiaries who are satisfied with their ability to obtain care

Access/Availability of Care
-Ratio of Dental Providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Beneficiary Characteristics
None

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-EPSDT Visit Rates
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percent of beneficiaries using any MH or SUD services

Health Plan/ Provider Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics
None

Clinical Topics
-Asthma management
-Child/Adolescent Dental Screening and Services

Standards/Accreditation

MCO/PIHP/PAHP Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Qualidigm

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

-On-site operations reviews
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

DISTRICT OF COLUMBIA

District of Columbia Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Maude Holt
Department of Health, Medical Assisstance Administrator
(202) 442-9074

State Website Address:

http://www.dchealth.dc.gov

PROGRAM DATA

Program Service Area:
Statewide

Initial Waiver Approval Date:
April 01, 1993

Operating Authority:
1915(b) - Waiver Program

Implementation Date:
April 01, 1994

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Waiver Expiration Date:
June 30, 2004

Enrollment Broker:
ACS, Inc.

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

For All Areas Phased-In:
Yes

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
No guaranteed eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Adult day treatment (MR only), Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Nurse mid-wife, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Addictionologists
-Clinical Social Workers
-Psychologists
-Psychiatrists
-Other Specialists Approved on a Case-by-Case Basis

DISTRICT OF COLUMBIA

District of Columbia Medicaid Managed Care Program

Enrollment

Populations Voluntarily Enrolled:
- TANF HIV Patients:Pregnant >26 Weeks
- Immigrant Children

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- TITLE XXI SCHIP
- Foster Care Children

Lock-In Provision:
12 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Advantage Health, Incorporated
DC Chartered Health Plan, Incorporated
Americaid Community Care
Health Right, Incorporated

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- Accreditation for Participation (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PIHP/PAHP Standards (see below for details)
- Monitoring of MCO/PIHP/PAHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Consumer Self-Report Data
None

Use of Collected Data
- Beneficiary Plan Selection
- Contract Standard Compliance
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Use of HEDIS
- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Incentives/sanctions to insure complete, accurate, timely encounter data submission
- Requirements for data validation
- Requirements for MCOs/PIHPs/PAHPs to collect and

Collections: Submission Specifications
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)
- Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)

maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Number of children with diagnosis of rubella(measles)/1,000 children
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Number of specialist visits per beneficiary

-Ratio of PCPs to beneficiaries

-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Beneficiary Characteristics
None

Health Plan/ Provider Characteristics
None

Performance Improvement Projects

Project Requirements
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Adult hearing and vision screening
-Asthma management
-Beta Blocker treatment after a heart attack
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Depression management
-Diabetes management/care
-Low birth-weight baby
-Newborn screening for heritable diseases
-Post-natal Care
-Pre-natal care
-Primary and behavioral health care coordination
-Well Child Care/EPSDT

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

EQRO Name
-Delmarva Foundation for Medical Care

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

-Validation of performance measures

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters
-Validation of encounter data

FLORIDA
Managed Health Care

CONTACT INFORMATION

State Medicaid Contact:	Bob Sanders Agency for Health Care Administration (AHCA) (850) 487-2355
State Website Address:	http://www.fdhc.state.fl.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Concera Corp.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
October 01, 1992

Implementation Date:
October 01, 1992

Waiver Expiration Date:
September 26, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Advanced Registered Nurse Practitioner, Ambulatory Surgical Center, Case Management, Chiropractic (limited direct access), County Health Department, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Pharmacy, Physician, Podiatric (limited direct access), Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Midwives
-Psychiatrists

FLORIDA

Managed Health Care

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:

- -Medicare Dual Eligible
- -Poverty Level Pregnant Woman
- -Other Insurance
- -Reside in Nursing Facility or ICF/MR
- -Enrolled in Another Managed Care Program
- -Hospice
- -Share of cost (Medically needy)

Populations Mandatorily Enrolled:

- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations
- -Foster Care Children
- -TITLE XXI SCHIP

Lock-In Provision:
12 month lock-in

FLORIDA
Managed Health Care

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Community Mental Health Services in Area 6 only, Dental, Durable Medical Equipment, EPSDT, Family Planning, Freestanding Dialysis Centers, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mental Health Targeted Case Management in specific area only, Outpatient Hospital, Pharmacy, Physician, Therapy, Transportation, Vision, X-Ray

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-State Hospital Services
-Hospice
-Medically Needy
-Medicaid Eligibles in Residential Committment Facilities
-Eligibles in Residential Group Care
-Children in Residential Treatment Facilities
-Residents in ADM Residential Treatment Facilities
-AIDs HCBS Waiver Enrollees
-Assisted Living HCBS Waiver Enrollees
-Prescribed Pediatric Extended Care Center Residents
-Qualified Medicare Beneficiaries - QMBs
-Medically Complex Children in CMS Program

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility criteria for special codes
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency

-Uses provider referrals to identify members of these groups

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup
Healthease
Humana Family Health Plan
Medipass
Preferred Medical Plan
Staywell Health Plan
Vista
AvMed - St. Augustine Health Care
Healthy Palm Beaches
JMH Health Plan
Neighborhood Health Partnership, Inc.
Provider Service Network
United Healthcare Plans of Florida

ADDITIONAL INFORMATION

PCCM enrollees in six counties receive mental health services through a capitated arrangement. Enrollees are allowed to choose either the fee-for-service or a capitated health plan. If the enrollee fails to make a choice, they are mandatory enrolled into a capitated health plan.

Dental and Transportation services are provided at the option of the Plan and the Agency.

Children may be enrolled in the prepaid dental health plan and a managed care organization or PCCM.

The Provider Service Network(PSN) plan is associated with this program and is structured as a fee-for-service model, it is another managed care option that links recipients to a provider network rather than just a primary care case provider. PSN is available to managed care eligibles who reside in Broward and Dade counties.

The 12 month guaranteed eligibility applies only to children under age 6.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
-Disenrollment Survey
-MCO/PIHP/PAHP Member Satisfaction Surveys

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Adolescent Well-care visits
-Asthma care - medication use
-Beta Blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

-Ratio of PCPs to beneficiaries

-Number of PCP visits per beneficiary

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Claims payable and IBNR by line of business
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Expenses by line of business
-Medical and Hospital expenses
-Medical loss ratio
-Net income
-Net worth
-Revenue by line of business
-State minimum reserve requirements
-Total assets
-Total liabilities
-Total revenue

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Health Plan/ Provider Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Beta Blocker treatment after a heart attack
-Breast cancer screening (Mammography)
-Breast cancer treatment
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Coordination of primary and behavioral health care
-Coronary artery disease prevention
-Coronary artery disease treatment
-Depression management
-Diabetes management/care
-Domestic violence
-Emergency Room service utilization
-ETOH and other substance abuse screening and treatment
-Hypertension management
-Lead toxicity
-Pharmacy management
-Pregnancy Prevention
-Pre-natal care
-Sexually transmitted disease screening
-Sexually transmitted disease treatment
-Sickle cell anemia management
-Treatment of myocardial infraction
-Tuberculosis screening and treatment
-Well Child Care/EPSDT

Non-Clinical Topics

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PIHP/PAHP Standards

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation for Deeming

-AAAHC (Accreditation Association for Ambulatory Health Care)
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-URAC

EQRO Organization

-None

Accreditation Required for Participation

-AAAHC (Accreditation Association for Ambulatory Health Care)
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-URAC

EQRO Name

-None

EQRO Mandatory Activities

-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
-Disenrollment Survey
-State-developed Survey

Use of Collected Data:

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care - medication use
-Cervical cancer screening rate

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

-Check-ups after delivery
-CHF Management
-Diabetes management/care
-ESRD Management
-Frequency of on-going prenatal care
-Hemophilia Management
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Pregnancy Prevention
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care

-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient and outpatient / 1,000 beneficiaries
-Number of primary care case manager visits per beneficiary

Provider Characteristics

-Board Certification
-Languages spoken (other than English)
-Provider turnover

Beneficiary Characteristics

-Disenrollment rate
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-CHF Management
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-ESRD Management
-Hemophilia Management
-Hepatitis B screening and treatment
-HIV/AIDS Prevention and/or Management
-Well Child Care/EPSDT

Non-Clinical Topics

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

FLORIDA
Prepaid Mental Health Plan

CONTACT INFORMATION

State Medicaid Contact:

Jorja Daniels
Agency for Health Care Administration
(813) 871-7600 x13

State Website Address:

http://www.fdhc.state.fl.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 31, 1996

Implementation Date:
March 01, 1996

Waiver Expiration Date:
November 12, 2003

Sections of Title XIX Waived:
- -1902(a)(1) Statewideness
- -1902(a)(10)(B) Comparability of Services
- -1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Full Capitation

Service Delivery

Included Services:
Crisis, IMD, Inpatient Mental Health, Mental Health Outpatient, Mental Health Outpatient Hospital, Mental Health Rehabilitation, Mental Health Support, Mental Health Targeted Case Management

Contractor Types:
- -Partnership between private managed care and local community MH inc.
- -PIHP/PAHP subcontracting with local community mental health providers and an Administrative Service Organization

Allowable PCPs:
- -Psychiatrists
- -Licensed Psychologists
- -Licensed Mental Health Practitioner

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
- -SOBRA CHILDREN
- -Section 1931 (AFDC/TANF) Children and Related Populations

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Poverty Level Pregnant Woman
-Medically Needed
-Other Insurance
-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Community-based care providers
-Department of Juvenile Justice
-Family Safety Program
-Forensic/Corrections System
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Behavioral Health, Inc

Florida Health Partners, Inc.

ADDITIONAL INFORMATION

Medicaid recipients who do not voluntarily choose a managed care plan are mandatorily assigned. In nine counties, recipients who choose or are mandatorily assigned to Medipass are automatically enrolled in the Prepaid Mental Health Plan. Children who are admitted to residential facilities designated by the Department of Juvenile Justice or the Child Welfare system are disenrolled from the Prepaid Mental Health Plan upon admission and then re-enrolled upon returning to the community. Children who are admitted to a Statewide Inpatient Pyschiatric Program (SIPP) are also disenrolled from the PMHP upon admission and re-enrolled upon returning to the community. Adults admitted to Florida community Treatment Team services are disenrolled from the PMPH and re-enrolled upon discontinuance of this service.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews

Use of Collected Data

-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

-Consumer/Beneficiary Focus Groups
-State-approved Survey

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

Validation: Methods

-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Medical record validation

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Coordination of mental health care with primary care
-Follow-up after hospitalization for mental illness
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality

-Change in level of functioning
-Patient satisfaction with care

Access/Availability of Care

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care

None

Health Plan/ Provider Characteristics

-Board Certification
-Credentials and numbers of professional staff

-Languages Spoken (other than English)

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics
-Availability and access to specialty therapies
-Availability of language interpretation services

Clinical Topics
-Coordination of primary and behavioral health care
-Coordination of Substance Abuse and Mental Health Care
-Depression management

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-State
-University

Accreditation Required for Participation
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

EQRO Name
-University of South Florida

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

FLORIDA

Statewide Inpatient Psychiatric Program

CONTACT INFORMATION

State Medicaid Contact:	Catharine Nelson Agency for Health Care Administration (850) 922-7343
State Website Address:	http://www.fdhc.state.fl.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
March 23, 1998

Implementation Date:
April 01, 1999

Waiver Expiration Date:
December 31, 2003

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

The program is a fee-for-service per diem all inclusive rate.

GEORGIA
Non-Emergency Transportation Broker Program

CONTACT INFORMATION

State Medicaid Contact:

Janine Gardner
Department of Community Health/Division of Medical
(404) 651-6917

State Website Address:

http://www.dch.state.ga.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 08, 1999

Implementation Date:
October 01, 1997

Waiver Expiration Date:
January 10, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Full Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Lock-In Provision:
Does not apply because State only contracts with one

managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

State contracts with a single broker in each of the states 5 non-emergency transportation regions to coordinate and provide non-emergency transportation services statewide.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data
None

Use of Collected Data
-Contract Standard Compliance

Use of HEDIS
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collection: Standardized Forms
None

Collections: Submission Specifications
-Guidelines for frequency of encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Accuracy Audits

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Type of Service

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Record Audits

Use of Services/Utilization
-Utilization by Type

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
None

GEORGIA

Preadmission Screening and Annual Resident Review (PASARR)

CONTACT INFORMATION

State Medicaid Contact:	Nell Moton-Kapple Department of Community Health/Division of Medical (404) 657-7211
State Website Address:	http://www.dch.state.ga.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 01, 1994

Implementation Date:
November 01, 1994

Waiver Expiration Date:
October 05, 2005

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Full Capitation

Service Delivery

Included Services:
Inpatient Mental Health Services, Mental Health/Mental Retardation

Contractor Types:
-Private Nursing Homes

Allowable PCPs:
-Psychiatrists
-Other Specialists Approved on a Case-by-Case Basis
-Psychologists
-Clinical Social Workers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Women
-Reside in ICF/MR
-Enrolled in another managed care program
-QMB
-Participate in HCBS Waiver
-Special Needs Children (State defined)
-American Indian/Alaskan Native

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Preadmission Screening and Annual Resident Review (PASARR)

ADDITIONAL INFORMATION

One contractor provides services to this population statewide. Special needs children include children with severe illnesses.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Focused Studies
-Ombudsman
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data
-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data
None

Use of HEDIS
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
None

GEORGIA
Preadmission Screening and Annual Resident Review (PASARR)

Collection: Standardized Forms
None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Access/Availability of Care
-Ratio of mental health providers to number of beneficiaries

Health Plan Stability/ Financial/Cost of Care
None

Beneficiary Characteristics
None

Health Status/Outcomes Quality
None

Use of Services/Utilization
None

Health Plan/ Provider Characteristics
None

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-OASYS

EQRO Mandatory Activities
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

IDAHO
Healthy Connections

CONTACT INFORMATION

State Medicaid Contact:	Pam Mason Bureau of Benefits & Reimbursement Policy (208) 364-1890
State Website Address:	http://www2.state.id.us/medicaid/index.htm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
November 26, 1993

Implementation Date:
October 01, 1993

Waiver Expiration Date:
September 21, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Childhood Immunizations through District Health, Chiropractic, Dental, Durable Medical Equipment, EPSDT, Family Planning, Flu shots, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Podiatry, Standard/HIV Testing and Treatment, Transportation, Vision, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants

IDAHO
Healthy Connections

Enrollment

Populations Voluntarily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
- Have Existing Relationship With a Non-participating PCP
- QMB-only or SLMB-only
- Live in a Non-participating County
- Retro-Eligibility Only
- Reside in Nursing Facility or ICF/MR
- Eligibility Period Less Than 3 Months
- If travel > 30 Minutes or 30 Miles

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- TITLE XXI SCHIP

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Developmental Disabilities Agency
- Education Agency
- Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy Connections

ADDITIONAL INFORMATION

Case management fee per member per month. The past year the program has been moving from a primarily voluntary program to a mandatory program. Healthy Connections is now mandatory in 33 of Idahos 44 counties. 33 of 44 counties are mandatory; exception granted for continuity of care & special needs.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
- Consumer Self-Report Data
- Disenrollment Surveys
- Enrollee Hotlines
- Enrollee Satisfaction Surveys
- Focused Studies
- Focuses Clinical Studies
- Grievance and Complaints

Use of Collected Data:
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting

-Ombudsman
-Provider Data
-Required Board Certification of Providers

Consumer Self-Report Data
-State-developed Survey

INDIANA
Hoosier Healthwise

CONTACT INFORMATION

State Medicaid Contact:

John Barth
Indiana Family and Social Services Administration
(317) 233-0237

State Website Address:

http://www.state.in.us/fssa/hoosier_healthwise/ind

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Lifemark Corporation

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
September 13, 1993

Implementation Date:
July 01, 1994

Waiver Expiration Date:
September 22, 2005

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Podiatry, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-Internists
-Obstetricians/Gynecologists
-General Practitioners
-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Illegal Aliens
-Refugees
-Spend Down
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver

Lock-In Provision:

No lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Chiropractic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Podiatry, Transportation, Vision, X-Ray

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:

-Foster Care Children
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Illegal Aliens
-Refugees
-Spend Down
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses combined enrollment form at certain locations to identify members of the group.

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

INDIANA
Hoosier Healthwise

Harmony Health Plans of Indiana

MDwise

Managed Health Services (MHS)

PCCM (PrimeStep)

ADDITIONAL INFORMATION

Inpatient psychiatric hospital and outpatient pyschiatric services are generally carved-out. However, when these services are provided by an acute care hospital or a PCP, they are included. The same coverage condition applies to inpatient and outpatient substance abuse services. Studies are conducted on a rotating basis for Process Quality under the PCCM section.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-State-developed Survey

Use of Collected Data

-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements

-Specifications for the submission of encounter data to the Medicaid agency

Collection: Standardized Forms

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Breast Cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Low birth-weight baby
-Pre-natal care
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PIHP/PAHP Standards
-NCQA recommended, not required.

Accreditation Required for Participation
None

INDIANA

Hoosier Healthwise

Accreditation for Deeming
None

EQRO Organization
-QIO-like entity

EQRO Name
-Tucker Alan, Incorporated

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters
-Validation of encounter data

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data
-State-developed Survey

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation

Performance Measures

Process Quality
-Adolescent immunization rate
-Breast Cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates in first 15 months of life

Access/Availability of Care
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries
-Statistical Data on Access to Pediatric care

Provider Characteristics
None

Health Status/Outcomes Quality
-Patient satisfaction with care

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of primary care case manager visits per beneficiary

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Cervical cancer treatment
-Childhood Immunization
-Low birth-weight baby
-Pre-natal care

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

-Well Child Care/EPSDT

INDIANA

Medicaid Select

CONTACT INFORMATION

State Medicaid Contact:

John Barth
Office of Medicaid Policy and Planning
(317) 233-0237

State Website Address:

http://www.medicaidselect.com/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
AmeriChoice

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 22, 2002

Implementation Date:
January 01, 2003

Waiver Expiration Date:
July 22, 2005

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Internists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Children Receiving Adoption Assistance
-Room and Board Assistance (RBA)

-Qualified Medicare Beneficiary (QMB)
-Special Low Income Beneficiary (SLIMB)
-Ticket to Work (MedWorks)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Developmental Disabilities Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medicaid Select

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Enrollee Hotlines
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

None

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Performance Measures

INDIANA
Medicaid Select

Process Quality
None

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Provider Characteristics
-Languages spoken (other than English)

Health Status/Outcomes Quality
-Patient satisfaction with care

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Percentage of beneficiaries with at least one dental visit

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Dental Screening and Services
-Diabetes management
-Emergency Room service utilization

Non-Clinical Topics
-Adults access to preventive/ambulatory health services

IOWA

Iowa Plan For Behavioral Health

CONTACT INFORMATION

State Medicaid Contact:	Dennis Janssen Department of Human Services (515) 281-8747
State Website Address:	http://www.dhs.state.ia.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 01, 1999

Implementation Date:
January 01, 1999

Waiver Expiration Date:
June 30, 2005

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:
Ambulance, Clinic, Detoxification, Enhanced Services, Home Health, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mental Health Outpatient, Outpatient Substance Use Disorders, X-ray

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Medicare Dual Eligibles

-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
- Eligible for Limited Benefit Package
- Age 65 or older
- Medically Needy with cash spenddown
- Reside in State Hospital-School

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Iowa Plan For Behavioral Health

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- Accreditation for Participation (see below for details)
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Focused Studies
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation

Consumer Self-Report Data
- Consumer/Beneficiary Focus Groups
- State-developed Survey

Use of HEDIS
- The State uses SOME of the HEDIS measures listed for Medicaid
- The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
- Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- Requirements for data validation
- Requirements for MCOs/PIHPs/PAHPs to collect and

Collections: Submission Specifications
- Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- Deadlines for regular/ongoing encounter data submission(s)

maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Follow-up after hospitalization for mental illness
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Dual Diagnosis - MH/SUD
-Emergency Room service utilization

Non-Clinical Topics
None

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Iowa Foundation for Medical Care

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
None

KENTUCKY

Human Service Transportation

CONTACT INFORMATION

State Medicaid Contact:	Cindy Stoops KY Department for Medicaid Services (502) 564-4923
State Website Address:	http://chs.state.ky.us/dms/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
February 01, 1996

Implementation Date:
June 01, 1998

Waiver Expiration Date:
June 02, 2005

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Full Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Human Service Transportation

ADDITIONAL INFORMATION

Title XXI SCHIP is included up to 150% of FPL.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)

Collections: Submission Specifications

None

Collection: Standardized Forms
None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Comparsion to plan claims payment data
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-None

Accreditation Required for Participation
None

EQRO Name
-Not Applicable

EQRO Mandatory Activities
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities
-Arranges for transportation related to EPSDT special services and organ transplantation

LOUISIANA
Community Care

CONTACT INFORMATION

State Medicaid Contact:

Leah Schwartzman
Department of Health and Hospitals
(225) 342-9520

State Website Address:

http://www.dhh.state.la.us

PROGRAM DATA

Program Service Area:
Parish

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
June 01, 1992

Implementation Date:
June 01, 1992

Waiver Expiration Date:
February 28, 2004

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Obstetricians/Gynecologists
-Pediatricians
-Family Practitioners
-Internists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-General Practitioners

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

- -Medicare (part A & B) beneficiaries
- -Recipients who have retroactive eligibility
- -Recipients who have other primary insurance that includes physician benefits
- -Presumptive Eligible (PE) recipients
- -Hospice residents
- -Medically high-risk recipients may warrant the first care and supervision of a non-primary care specialist
- -Eligibility Period Less Than 3 Months
- -Reside in Nursing Facility or ICF/MR
- -American Indian/Alaskan Native
- -Recipients who are 65 or older
- -Residents of Psychiatric facilities
- -Medically needy recipients
- -Foster children, or children receiving adoption assistance
- -Office of Youth Development recipients
- -Recipients in SURS lock-in (except "pharmacy-only" lock in)

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- -Reviews complaints and grievances to identify members of these groups
- -Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Education Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care Program

ADDITIONAL INFORMATION

Program includes a $3 monthly case management fee. The program will be statewide by 12/1/2003.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- -Consumer Self-Report Data
- -Enrollee Hotlines
- -Focused Studies
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -Provider Data

Consumer Self-Report Data

- -A State Developed suvey based on CAHPS questions for both adults and children

Use of Collected Data:

- -Fraud and Abuse
- -Health Services Research
- -Monitor Quality Improvement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Provider Profiling
- -Regulatory Compliance/Federal Reporting

-Consumer/beneficiary Focus Groups

Performance Measures

Process Quality

-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Immunizations for two year olds
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care

-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Provider Characteristics

-Board Certification
-Languages spoken (other than English)

Health Status/Outcomes Quality

-Patient satisfaction with care

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Beneficiary Characteristics

-Beneficiary need for interpreter
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics

-Asthma management
-Well Child Care/EPSDT

Non-Clinical Topics

None

MICHIGAN

Comprehensive Health Plan

CONTACT INFORMATION

State Medicaid Contact:

Judith Kloko
Michigan Department of Community Health
(517) 241-5714

State Website Address:

http://www.michigan.gov/mdch

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Michigan Enrolls

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 30, 1997

Implementation Date:
July 01, 1997

Waiver Expiration Date:
April 21, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Durable Medical Equipment, Emergency, EPSDT, Family Planning, Health education, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Intermittent or short-term restorative or rehab skilled nursing care, Laboratory, Maternal and Infant Support, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Prosthetics and Orthotics, Transplant, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Physician assistants

Enrollment

MICHIGAN

Comprehensive Health Plan

Populations Voluntarily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

- -Reside in Nursing Facility or ICF/MR
- -Other Insurance
- -Participate in HCBS Waiver
- -Enrolled in Another Managed Care Program
- -Spenddown
- -Court Wards
- -Kosovo Refugees
- -Medicare dual eligibles
- -Persons enrolled in CSHCS
- -Person with full medicaid coverage, including those in the state medical program or pluscare

Populations Mandatorily Enrolled:

- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Monthly enrollment file flags SSI and adoptive kids indicators to health plans

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Education Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Public Health Agency
- -Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Botsford Health Plan
Community Care Plan
Great Lakes Health Plan
HealthPlus Partners, Inc.
McLaren Health Plan
Molina Healthcare of Michigan
Physicians Health Plan of Mid-Michigan - Family Care
Priority Health Government Programs, Inc.
Upper Penninsula Health Plan
Cape Health Plan
Community Choice Michigan
Health Plan of Michigan
M-Caid HMO
Midwest Health Plan
Omnicare Health Plan
Physicians Health Plan of Southwest Michigan
Total Health Care
Wellness Plan

ADDITIONAL INFORMATION

The enrollment basis for included populations will depend if they fall under the Special needs population. Michigan Special Needs Children include children who have one of any 2700 different qualifying physical diagnoses, if the condition has the necessary level of severity and chronicity to qualify.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Accreditation for participation, member or applied for membership
-Complaint and Grievance Monitoring
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Choice Monitoring
-Provider Data
-Provider Selection Monitoring
-Timely and Compliant Claims Reporting
-Timely Provider File Submissions

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor quality improvement efforts
-Monitor service provision
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data

-CAHPS
    Adult Medicaid Questionaire
    Child Medicaid Questionaire

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to promote completeness, accuracy and timeliness of encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-County

State conducts general data completeness assessments

Yes

-Zip code

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia screening
-Diabetes management/care
-Immunizations for two year olds
-Initiation of prenatal care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Smoking prevention and cessation
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs

Performance Improvement Projects

Project Requirements
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-Plan is required to have applied or be accredited

Accreditation for Deeming
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Name
-Delmarva Foundation for Medical Care, Inc.

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Conduct studies on quality and access that focus on a particular aspect of clinical or non-clinical services
-Medstat (collects and validates encounter data)
-Medstat collects encounter data in collaboration with Delmarva
-Validation of client level data, such as claims and encounters

MINNESOTA
* Consolidated Chemical Dependency Treatment Fund (CCDTF)

CONTACT INFORMATION

State Medicaid Contact:	Mary Kennedy Minnesota Department of Human Services (651) 282-9921
State Website Address:	http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1988

Implementation Date:
January 01, 1988

Waiver Expiration Date:
March 23, 2004

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice
-1902(a)(30) Utilization Review

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

County Case Manager - Fee-for-Service

Service Delivery

Included Services:
Extended Rehabilitation (Extended Care), Inpatient Substance Use Disorders (Fee-Standing and Hospital-Based), Outpatient Substance Use Disorders, Transitional Rehabilitation (Halfway House)

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

-TITLE XXI SCHIP
-All Medicaid Recipients Are Eligible For The CCDTF Program.

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program that covers CD services

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Consolidated Chemical Dependency Treatment Fund (CCDTF)

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

None

Performance Measures

Process Quality

-Track number of placements by beneficiary characteristics
-Track number of placements by type of service

Health Status/Outcomes Quality

None

Access/Availability of Care

None

Use of Services/Utilization

None

MINNESOTA

* Consolidated Chemical Dependency Treatment Fund (CCDTF)

Provider Characteristics

-Licensing for provider/entity and its staff

Beneficiary Characteristics

-Age
-County of residence
-Household size
-Information of beneficiary ethnicity/race
-Marital status

MISSOURI

MC+ Managed Care/1915b

CONTACT INFORMATION

State Medicaid Contact:	Susan Eggen Department of Social Services, Division of Medical Svcs. (573) 751-5178
State Website Address:	http://www.state.mo.us

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Policy Studies, Inc.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 01, 1995

Implementation Date:
September 01, 1995

Waiver Expiration Date:
March 14, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Adult Day Care, Ambulatory Surgical Care, Case Management, Clinic - FQHC/RHC, Comprehensive Day Rehabilitation, Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physician, Prenatal Case Management, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-PCP Teams
-PCP Clinics - which can include FQHCs/RHCs

MISSOURI
MC+ Managed Care/1915b

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- -Participate in HCBS Waiver
- -Enrolled in Another Managed Care Program
- -General Relief Participants
- -AIDS Waiver program participants
- -Permanently and totally disabled individuals
- -Aid to the Blind and Blind Pension Individuals
- -Children with Developmental Disabilities Program
- -Medicare Dual Eligible
- -Reside in Nursing Facility or ICF/MR
- -Presumptive Eligibility Program for Pregnant Women
- -American Indian/Alaskan Native
- -Medical assistance for workers with disabilities
- -Presumptive Eligibility for Children

Populations Mandatorily Enrolled:
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Foster Care Children
- -MC+ for Pregnant Women
- -Children in the Legal Custody of Department of Social Services
- -Mentally Retarded Developmentally Disabled (MRDD) Waiver participants
- -Special Needs Children (State defined)
- -MO is a 209(b) State and has no specific eligibility categories for the special needs populations

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- -Data Match with Other State Agencies
- -Health Risk Assessment
- -Helpline
- -MCO uses ER Encounters
- -MCOs use Drug Usage
- -MCOs use Hospital Admissions
- -MCOs use Hospital Encounters
- -Reviews grievances and appeals to identify members of these groups
- -Surveys medical needs of enrollee to identify members of these groups
- -Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Education Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Other State Agencies as necessary
- -Public Health Agency
- -Social Security Administration

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross Blue Shield of Kansas City, Blue Advantage+ Plus
Family Health Partners
HealthCare USA
Missouri Care
Community Care Plus
FirstGuard
Mercy Health Plans

ADDITIONAL INFORMATION

Vision services - Eye glasses for memebers 21 and over are not covered except for one pair following catarac surgery. Dental services - for members 21 and older limited to dentures and trauma to the mouth or teeth as a result of injury. Medicaid eligibles in the included populations who are receiving Supplemental Security Income (SSI), who meet the SSI medical disability definition, or who receive adoption subsidy may choose to enroll or voluntarily disenroll from MC+ Managed Care at any time. Special Needs Children enrollment is mandatory but individuals may request to opt out. HealthCare USA plan participates in Eastern, Central, and Western Regions. Special Needs Children enrollment is mandatory but individuals may request to opt out.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman (Western and Eastern Regions only)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Children with Special Needs Questionnaire

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement - EPSDT
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term

Collections: Submission Specifications

-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

care facilities,

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-C-Section Rates
-Dental services
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Mental Health Utilization
-Outcomes of pregnancy
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Preventable Hospitalization under age 18
-Smoking during pregnancy
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care

-Average distance to PCP

Use of Services/Utilization

-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care

-Missouri Department of Insurance monitors and tracks Health Plan stability/financial/cost of care

Health Plan/ Provider Characteristics

-Languages Spoken (other than English)

Beneficiary Characteristics

-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Behavioral Health Concepts (BHC)

EQRO Mandatory Activities
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

MONTANA
Passport To Health

CONTACT INFORMATION

State Medicaid Contact:	Mary Angela Collins Montana Department of Public Health and Human Services (406) 444-4146
State Website Address:	http://www.dphhs.state.mt.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
No

Guaranteed Eligibility:
1 month guaranteed eligibility

Initial Waiver Approval Date:
August 31, 1993

Implementation Date:
January 01, 1994

Waiver Expiration Date:
April 24, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Dialysis, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home and Community Based Waiver, Home Health, Home Infusion Therapy, Home Personal Attendant, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nursing Homes, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplants, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Indian Health Service (IHS) Providers
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Geriatrics
-Internal Medicine
-Pediatrics
-Nephrologist
-Pediatricians

MONTANA
Passport To Health

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Eligibility Period Less Than 3 Months
-Medically Needy
-Restricted Card Program
-Area Without Managed Care
-Subsidized Adoption
-Only Retroactive Eligibility
-Home and Community Waiver

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Nurses
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Passport to Health

ADDITIONAL INFORMATION

Program includes a $3.00 case management fee.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal

MONTANA
Passport To Health

-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
-State-developed Survey

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Diabetes management/care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care

-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Provider Characteristics

-Board Certification

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Use of Services/Utilization

-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Beneficiary Characteristics

-Disenrollment rate
-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Low birth-weight baby
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics

-Native American Adults access to preventative/ambulatory health services
-Native American Children access to preventative/ambulatory health services
-Native American Children's access to primary care practitioners

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1915(b)

CONTACT INFORMATION

State Medicaid Contact:

David Cygan
Nebraska Medicaid
(402) 471-9050

State Website Address:

http://www.hhss.state.ne.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Nebraska Health Connection/Access Medicaid

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 05, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2005

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Transportation, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-American Indian/Alaskan Native
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Presumptive Eligibles
-Transplant Recipients
-Women with Cancer

Lock-In Provision:

1 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Transportation, Vision, X-Ray

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Presumptive Eligibility
-Transplant Recipients
-Women with Cancer

Populations Mandatorily Enrolled:

-American Indian/Alaskan Native
-Special Needs Children (State defined)

Lock-In Provision:

1 month lock-in

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1915(b)

Specialty Physician Case Management (SPCM) Program - Fee-for-Service

Service Delivery

Included Services:

EPSDT, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Intensive case management, Laboratory, Opiate Treatment Program, Outpatient Mental Health, Outpatient Substance Use Disorders, Transportation, X-Ray

Allowable PCPs:

-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-Presumptive Eligibles
-Transplant Recipients
-Women with Cancer
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program

Populations Mandatorily Enrolled:

-Special Needs Children (State defined)
-American Indian/Alaskan Native

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Title V Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Magellan Behavioral Health
Share Advantage
Primary Care Plus

ADDITIONAL INFORMATION

Children on SSI, Children in Foster Care or Out-of-Home Placements, and Children Eligible For and Receiving Title V Services.

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1915(b)

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- -Accreditation for Participation (see below for details)
- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -Focused Studies
- -MCO/PIHP/PAHP Standards (see below for details)
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)

Consumer Self-Report Data

- -Consumer/Beneficiary Focus Groups
- -State-developed Survey

Use of Collected Data

- -Beneficiary Plan Selection
- -Contract Standard Compliance
- -Fraud and Abuse
- -Health Services Research
- -Monitor Quality Improvement
- -Plan Reimbursement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting

Use of HEDIS

- -The State uses SOME of the HEDIS measures listed for Medicaid
- -The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
- -State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

- -Incentives/sanctions to insure complete, accurate, timely encounter data submission
- -Requirements for data validation
- -Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
- -Specifications for the submission of encounter data to the Medicaid agency
- -Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

- -Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- -Deadlines for regular/ongoing encounter data submission(s)
- -Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
- -Guidelines for frequency of encounter data submission
- -Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

- -NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- -UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

Validation: Methods

- -Automated edits of key fields used for calculation (e.g. codes within an allowable range)
- -Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

- -Date of Service
- -Provider ID
- -Medicaid Eligibility
- -Plan Enrollment
- -Diagnosis Codes
- -Procedure Codes
- -Revenue Codes

State conducts general data completeness assessments

Yes

Performance Measures

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1915(b)

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Check-ups after delivery
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-(Newborn) Failure to thrive
-Low birth-weight baby
-Pre-natal care

Non-Clinical Topics
None

Standards/Accreditation

MCO/PIHP/PAHP Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation Required for Participation
-Department of Insurance Certification
-NCQA (National Committee for Quality Assurance)

Accreditation for Deeming
None

EQRO Name
-Nebraska Foundation for Medical Care

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1915(b)

EQRO Organization
-QIO-like entity

EQRO Mandatory Activities
-Validation of performance improvement projects

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
-Consumer/beneficiary Focus Groups
-State-developed Survey

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
None

Access/Availability of Care
-Average distance to primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
None

Provider Characteristics
-Languages spoken (other than English)
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

NEW JERSEY

New Jersey Care 2000+ (1915 {b})

CONTACT INFORMATION

State Medicaid Contact:	Jill Simone, MD Office of Managed Health Care (609) 588-2705
State Website Address:	http://www.state.nj.us/humanservices/dmahs/index.h

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 18, 2000

Implementation Date:
October 01, 2000

Waiver Expiration Date:
December 29, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Audiology, Chiropractor, Dental, Durable Medical Equipment/Assistive Technology Devices, Emergency Medical Care, EPSDT, Family Planning, Hearing Aid Service, Home Health, Hospice, Immunization, Inpatient hospital including acute care, rehabilitation and special hospitals, Laboratory, Medical Supplies, MH/SUD for enrollees who are clients of the Division of Developmental Disabilities, Optical Appliances, Optometrist, Organ Transplants, Outpatient Hospital, Pharmacy, Physician, Podiatrist, Post-acute Care, Preventive Health Care and Counseling and Health Promotion, Prosthetics and Orthotics including certified shoe provider, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Family Practitioners
-Physician Assistants
-Certified Nurse Specialists

Enrollment

NEW JERSEY
New Jersey Care 2000+ (1915 {b})

Populations Voluntarily Enrolled:

-Medicare dual eligibles

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program Without Department of Human Services Contract
-Participate in HCBS Waiver (except DDD/CCW non-duals)
-Individuals institutionalized in an inpatient psychiatric facility
-Full-time students attending school but resides outside the country
-Medically needy and presumptive eligibility beneficiaries
-In out of state placements
-Individuals with eligibility period that is only retroactive

Populations Mandatorily Enrolled:

-Non duals DDD/CCW children < 21
-Non duals Blind and Disabled Children and Related Populations < 21

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of New Jersey, Inc.
Health Net
University Health Plans, Inc.
AMERIGROUP New Jersey, Inc.
Horizon Mercy

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Use of Collected Data

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

-Performance Measures (see below for details)
-Provider Data
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
Adult Medicaid AFDC Questionnaire
Survey - included ABD adult and children specific questions. Results not separated by age group.

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Comparison of reported changes to reasonable and customary fees.

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Adolescent well-care visit rates

Health Status/Outcomes Quality

-Lead Toxicity Study
-Member Satisfaction (CAHPS)

-Analysis of pharmaceutical services
-Asthma care - medication use
-Breast Cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Quality and utilization of dental services
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care

-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries
-Ratio of pharmacies to number of beneficiaries

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (i.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics

-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs

Use of Services/Utilization

-Average inpatient length of stay
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Inpatient days per 1000 members
-Pharmacy services per member
-Physician visits per 1000 members

Health Plan/ Provider Characteristics

None

Performance Improvement Projects

Project Requirements

-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics

-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management/care
-Lead Screenings
-Postnatal
-Prenatal care
-Well Child Care/EPSDT

Non-Clinical Topics

-Adults access to preventive/ambulatory health services

-Children's access to primary care practitioners

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-PRONJ The Healthcare Quality Improvement Organization of New Jersey, Inc.

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Medical Record review
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

NEW MEXICO

SALUD!

CONTACT INFORMATION

State Medicaid Contact:	Pao Her HSD-Medical Assistance Division (505) 827-1329
State Website Address:	http://www.state.nm.us/hsd/mad/salud.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
May 13, 1997

Implementation Date:
July 01, 1997

Waiver Expiration Date:
June 30, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Emergency Room, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

NEW MEXICO
SALUD!

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Home and Community Based Waiver
-Poverty Level Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Native Americans
-Clients participating in the health insurance premium program (HIPP)
-Children and adolescents in out-of-state foster care or adoption placement

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses fee for service claims data
-Uses history of prior authorization of special services and equipment

Agencies with which Medicaid Coordinates the Operation of the Program:

-Department of Health
-Mental Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Cimarron
Presbyterian Salud
Lovelace

ADDITIONAL INFORMATION

HMOs designate PCPs.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Track Health Service provision

-Provider Data

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
-State-developed Survey

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Provider ID
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit

Access/Availability of Care

-Average distance to PCP
-Ratio of PCPs to beneficiaries

Health Status/Outcomes Quality

-Patient satisfaction with care

Use of Services/Utilization

-Percentage of beneficiaries with at least one dental visit

NEW MEXICO
SALUD!

Health Plan Stability/ Financial/Cost of Care
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs

Health Plan/ Provider Characteristics
-Provider turnover

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics
-Adults access to preventive/ambulatory health services

Clinical Topics
-Well Child Care/EPSDT

Standards/Accreditation

MCO/PIHP/PAHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation for Deeming
-NCQA (National Committee for Quality Assurance)

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
-NCQA (National Committee for Quality Assurance)

EQRO Name
-IPRO

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

NEW YORK

Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:	Tim Perry-Coon Office of Medicaid Management, NY State Dept (518) 474-9266
State Website Address:	http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
January 16, 1996

Implementation Date:
July 01, 1996

Waiver Expiration Date:
November 14, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Full Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-All Medicaid Beneficiaries

NEW YORK
Non-Emergency Transportation

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Transportation Agency

ADDITIONAL INFORMATION

Selective contracting for non-emergency transportation.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Not Applicable

Use of Collected Data
-Not applicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
None

EQRO Mandatory Activities
-None

EQRO Optional Activities
None

NORTH CAROLINA
Access II/III - 1915(b)

CONTACT INFORMATION

State Medicaid Contact:	Deborah Bowen Division of Medical Assistance (919) 857-4226
State Website Address:	http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 01, 1998

Implementation Date:
July 01, 1998

Waiver Expiration Date:
August 05, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractor, Dialysis, Durable Medical Equipment, EPSDT, Hearing (excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Outpatient Hospital, Personal Care, Physician, Private Duty Nursing, X-Ray

Allowable PCPs:
-Hospital Outpatient Clinics
-Community Health Centers
-Other Specialist Approved on a Case-by-Case Basis
-Health Clinics
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Health Departments

NORTH CAROLINA
Access II/III - 1915(b)

Enrollment

Populations Voluntarily Enrolled:

-Foster Care Children
-Native Americans who are members of a Federally-recognized tribes
-Medicare/Medicaid Dual Eligibles
-Adoption Subsidy Children

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period that is only Retroactive
-Private Insurance and PCP not willing to participate
-Native American choosing to be exempt

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations
-Special Needs Children (BBA defined)

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Pilot Initiative occurring in Buncombe County that integrates and collaborates with all community age
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses ACCESS II Health assessment form
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access II/III

ADDITIONAL INFORMATION

An Administrative Entity is paid an additional PCCM case management fee of $2.50 per recipient per month participating in Access II/III to monitor care and implement disease management initiatives and target preventive services. ACCESS II/III manages the highest risk Medicaid enrollees to improve coordination and continuity of care.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

NORTH CAROLINA
Access II/III - 1915(b)

Quality Oversight Activities:
-Care Management
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Utilization Claims Data focusing on High Cost and High Risk

Consumer Self-Report Data
-Ages and Stages Questionnaire for Developmental Evaluation
-CAHPS
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire
  Child with Special Needs Questionnaire
-Patient Satisfaction Surveys
-Smoking Cessation Readiness Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Performance Measures

Process Quality
-Adolescent immunization rate
-Annual eye exams for diabetics
-Asthma Action Plans submitted to Schools
-Asthma care - medication use
-Asthma Management
-Cost Effective Medication Use
-Depression medication management
-Influenza vaccination rate
-Lead screening rate
-Poly Pharmacy Review
-Staging of asthmatics and appropriate use of medication
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
-Asthma Management
-Diabetes Management
-Emergency Department Rates
-Hospitalization Rates
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-After Hours and Weekend Availability
-Average wait time for an appointment with primary care case manager
-Complaint Monitoring
-Emergency Department Rates
-Ratio of primary care case managers to beneficiaries
-Satisfaction Survey

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Inpatient and ED utilization with diagnosis of asthma or diabetes
-Number of home health visits per benificiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics
-Bilingual staff and educational material
-Languages spoken (other than English)
-Patient/family satisfaction and understanding services
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Complaints and Satisfaction Survey
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM
-Reason for disenrollment or provider change

Performance Improvement Projects

Clinical Topics
-ADHD Management
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Ancillary Services Management

Non-Clinical Topics
-Availability of language interpretation services
-Children's access to primary care practitioners
-Community Communication and Collaboration with High-Risk Clients

NORTH CAROLINA
Access II/III - 1915(b)

-Asthma management
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Coordination of primary and behavioral health care
-Depression management
-Diabetes management
-Emergency Room service utilization
-Fever Management
-Gastroenteritis
-Lead toxicity
-Otitis Media management
-Poly Pharmacy Management
-Pregnancy Prevention
-Pre-natal care
-Prevention of Influenza
-Well Child Care/EPSDT
-Coordination of Wrap-Around Services

NORTH CAROLINA
Carolina ACCESS 1915(b)

CONTACT INFORMATION

State Medicaid Contact:

Deborah Bowen
Division of Medical Assistance
(919) 857-4226

State Website Address:

http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1991

Implementation Date:
April 01, 1991

Waiver Expiration Date:
August 05, 2003

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Dialysis, Durable Medical Equipment, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Outpatient Hospital, Personal Care, Physician, Private Duty Nursing, X-Ray

Allowable PCPs:
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Public Health Departments
-Hospital Outpatient Clinics
-Community Health Centers
-Health Clinics

NORTH CAROLINA
Carolina ACCESS 1915(b)

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Pregnant Women
-Medicare/Medicaid Dual Eligibles
-American Indians who are members of Federally-recoginzed tribes

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Period that is only Retroactive
-Enrolled in Another Managed Care Program
-Native Americans choosing to be exempt
-Terminally Ill
-Private Insurance and PCP Not Willing to Participate

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Children and Related Populations
-Special Needs Children (BBA Defined except for "Katie Beckett" children)

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carolina Access

ADDITIONAL INFORMATION

Enrollment Broker: Public Consulting Group, is only used in Mecklenburg County.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Do Not Use the Data Collected

NORTH CAROLINA
Carolina ACCESS 1915(b)

Consumer Self-Report Data
-CAHPS
- Child Medicaid AFDC Questionnaire
- Child Medicaid SSI Questionnaire
- Child with Special Needs Questionnaire

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of specialist visits per beneficiary
-Outpatient visits per 1,000 beneficiaries

Provider Characteristics
None

Beneficiary Characteristics
-Change of PCP and Reason for Change
-Patient Education
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Asthma management
-Attention Deficit/Hyperactivity Disorder
-Childhood Immunization
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
None

NORTH CAROLINA
Health Care Connection 1915(b)

CONTACT INFORMATION

State Medicaid Contact:

Deborah Bowen
Division of Medical Assistance
(919) 857-4226

State Website Address:

http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
Public Consulting Group

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 01, 1991

Implementation Date:
July 01, 1996

Waiver Expiration Date:
August 05, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Adult Preventative Medicine, Ambulance, Chiropractic, Clinic Services-except for Mental Health and Substance Use Disorders, Diagnostic, Dialysis, Durable Medical Equipment, Emergency Room, EPSDT, Family Planning and Supplies, Hearing Aids, Home Health, Home Infusion Therapy, Hospice, Immunization, Inpatient Hosptial Except for Mental Health and Substance Use Disorders, Laboratory, Midwife, Occupational, Speech and Physical Therapy, Optical Supplies, Outpatient Hospital, Physician Services including Physician Assistants and Family Nurse Practitioners, Podiatry, Postpartum Newborn Home Visit -Maternal Assessment, Postpartum Newborn Home Visit-EPSDT, Postpartum Newborn Home Visit-Newborn Assessment, Private Duty Nursing, Prosthetics/Orthotics, Sterilization, Total Parenteral Nutrition, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Physician Assistants
-Pediatricians
-Other Specialists Approved on a Case-by-Case Basis

NORTH CAROLINA
Health Care Connection 1915(b)

Enrollment

Populations Voluntarily Enrolled:
- -Foster Care Children
- -Adoption Subsidy Children

Subpopulations Excluded from Otherwise Included Populations:
- -Medicare Dual Eligible
- -Reside in Nursing Facility or ICF/MR
- -Participate in HCBS Waiver
- -Enrolled in Another Managed Care Program
- -Eligibility Period that is only Retro-active

Populations Mandatorily Enrolled:
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Blind/Disabled Children and Related Populations
- -Pregnant Women
- -Special Needs Children (BBA defined)

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- -Reviews complaints and grievances to identify members of these groups
- -Surveys medical needs of enrollee to identify members of these groups
- -Uses eligibility data to identify members of these groups
- -Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Maternal and Child Health Agency
- -Public Health Agency
- -Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Wellpath Select, Inc. dba Southcare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -Focused Studies
- -MCO/PIHP/PAHP Standards (see below for details)
- -Monitoring of MCO/PIHP/PAHP Standards
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -Provider Data

Use of Collected Data
- -Contract Standard Compliance
- -Health Services Research
- -Monitor Quality Improvement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting
- -Track Health Service provision

NORTH CAROLINA
Health Care Connection 1915(b)

Consumer Self-Report Data
-CAHPS
  - Child Medicaid AFDC Questionnaire
  - Child Medicaid SSI Questionnaire
  - Child with Special Needs Questionnaire

-Complaints/Grievances/Appeals

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Units of Service

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate

Health Status/Outcomes Quality
-Children with Special Health Care Needs Assessment
-New Member Health Assessment
-Patient satisfaction with care

-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care

-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Children's Access to Therapy Services
-Involuntary Disenrollment
-Non-authorized Visits
-Ratio of PCPs to beneficiaries
-Referral denials

Use of Services/Utilization

-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics

-After Hours Survey
-Enrollment by Product Line
-Languages Spoken (other than English)
-Provider satisfaction survey
-Provider turnover

Beneficiary Characteristics

-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs

Performance Improvement Projects

Project Requirements

-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Well Child Care/EPSDT

Non-Clinical Topics

-2003 Provider Satisfaction Survey
-Initial Health Assessment/Health Check Review

Standards/Accreditation

MCO/PIHP/PAHP Standards

-NCQA (National Committee for Quality Assurance) Standards
-QARI (Quality Assurance Reform Initiative)
-State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Medical Review of North Carolina
-Myers and Stauffers

EQRO Organization

-QIO-like entity
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities

-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters
-Validation of encounter data

OHIO
PremierCare

CONTACT INFORMATION

State Medicaid Contact:	Cynthia Burnell Bureau of Managed Health Care (614) 466-4693
State Website Address:	http://www.state.oh.us/odjfs/index.stm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Automated Health System Inc.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
May 23, 2001

Implementation Date:
July 01, 2001

Waiver Expiration Date:
June 30, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All other Ohio Medicaid services, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

OHIO

PremierCare

Populations Voluntarily Enrolled:

- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Foster Care Children
- -TITLE XXI SCHIP
- -Special Needs Children (BBA defined)
- -Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

- -Reside in Nursing Facility or ICF/MR
- -Participate in HCBS Waiver
- -All except TANF and TANF-Related Medicaid eligibles
- -Medicare Dual Eligible
- -Other Insurance
- -Eligibility only Retroactive

Populations Mandatorily Enrolled:

- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -TITLE XXI SCHIP
- -Special Needs Children (BBA defined)
- -Special Needs Children (State defined)

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- -Surveys medical needs of enrollee to identify members of these groups
- -Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Education Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Public Health Agency
- -Social Services Agency
- -Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

CareSource
MediPlan
Qualchoice Health Plan
Family Health Plan
Paramount Health Care
Summacare

ADDITIONAL INFORMATION

Multiple enrollment basis for included population is because enrollment is mandatory in counties designated as such and voluntary in counties designated as such. An enrollment designation called "Preferred Option" is found in six counties. In these counties, Medicaid eligibles that do not choose fee for service Medicaid are enrolled in the single MCO operating in the county. Enrollees may opt out of the MCO and return to fee for service at any time. An enrollee under the age of 21 which has one or more of the following medical conditions: In selected counties enrollment is voluntary, mandatory, or "preferred option."

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- -Accreditation for Deeming (see below for details)
- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines

Use of Collected Data

- -Beneficiary Plan Selection
- -Contract Standard Compliance
- -Health Services Research
- -Monitor Quality Improvement

OHIO

PremierCare

-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

Yes

Performance Measures

OHIO
PremierCare

Process Quality
-Adolescent well-care visit rates
-Asthma care - medication use
-Check-ups after delivery
-Dental services
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information on primary languages spoken by beneficiaries
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Well Child Care/EPSDT

Non-Clinical Topics
-Timely identification, assessment, and case management for members with special health care needs

Standards/Accreditation

OHIO
PremierCare

MCO/PIHP/PAHP Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation for Deeming
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)
-URAC

EQRO Organization
-QIO-like entity

Accreditation Required for Participation
None

EQRO Name
-Delmarva Foundation for Medical Care

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data

OREGON

* Transportation Program

CONTACT INFORMATION

State Medicaid Contact:	Larry Daimler Office of Medical Assistance Programs (503) 945-6493
State Website Address:	http://www.omap.hr.state.or.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Initial Waiver Approval Date:
September 01, 1994

Implementation Date:
September 01, 1994

Waiver Expiration Date:
July 25, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

Guaranteed Eligibility:
None

ADDITIONAL INFORMATION

The State contracts with brokers on a per ride fee-for-service basis. The brokers subcontract with providers on a per ride fee-for-service basis who provide non-emergency transportation services.

PENNSYLVANIA
Family Care Network

CONTACT INFORMATION

State Medicaid Contact:

Candy Spahr
Pennsylvania Department of Welfare
(717) 772-6162

State Website Address:

http://state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
October 14, 1993

Implementation Date:
February 01, 1994

Waiver Expiration Date:
October 26, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Psychiatrists
-Other Specialists Approved on a Case-by-Case Basis
-Specialist Who Meets Special Needs of Client

Enrollment

PENNSYLVANIA
Family Care Network

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Blind/Disabled Children and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Restricted Beneficiaries
-State Blind Pension Recipients

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Education Agency
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Family Care Network

ADDITIONAL INFORMATION

Enrollment focuses on Medicaid recipients under age 21. There is a monthly management fee of $3.00 paid to the provider for each recipient in his panel.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Contract Standard Compliance
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
-State-developed Survey

Performance Measures

PENNSYLVANIA
Family Care Network

Process Quality
None

Health Status/Outcomes Quality
None

Access/Availability of Care
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
None

Non-Clinical Topics
-Availability of language interpretation services
-Children's access to primary care practitioners

PENNSYLVANIA
HealthChoices

CONTACT INFORMATION

State Medicaid Contact:

Mike Jacobs
Pennsylvania Department of Welfare
(717) 772-6300

State Website Address:

http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Benova

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 31, 1996

Implementation Date:
February 01, 1997

Waiver Expiration Date:
June 16, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) State mandate to PIHP or PAHP

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Emergency Ambulance Transportation, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility for First 30 Days, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners

PENNSYLVANIA
HealthChoices

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-State Only Categorically and Medically Needy
-Pregnant Women
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-State Blind Pension Recipients
-Monthly Spend Downs
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:
Behavioral Health Rehab Services for Children and Adolescents, Crisis, Detoxification, Family Based Services, Inpatient Mental Health Services, Inpatient Substance Use Disorders Services, Mental Health Outpatient, Mental Health Residential, Mental Health Support, Opioid Treatment Programs, Outpatient Substance Use Disorders Services, Pharmacy, Residential Substance Use Disorders Treatment Programs

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-State Blind Pension Recipients
-Monthly Spend Downs
-Reside in Nursing Facility or ICF/MR

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

PENNSYLVANIA
HealthChoices

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of Pennsylvania
AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan
County of Adams - Community Care Behavioral Health
County of Allegheny - Community Care Behavioral Health
County of Armstrong - Value Behavioral Health of PA
County of Beaver - Value Behavioral Health of PA
County of Berks - Community Care Behavioral Health (CCBH)
County of Bucks - Magellan Behavioral Health of PA, Inc.
County of Butler - Value Behavioral Health of PA
County of Chester - Magellan Behavioral Health
County of Cumberland - Community Behavioral Healthcare Network of PA, Inc.
County of Dauphin - Community Behavioral Healthcare Network of PA, Inc.
County of Delaware - Magellan Behavioral Health of PA, Inc.
County of Fayette - Value Behavioral Health of PA
County of Indiana - Value Behavioral Health of PA
County of Lancaster - Community Behavioral Healthcare Network of PA, Inc.
County of Lawrence - Value Behavioral Health of PA
County of Lebanon - Community Behavioral Healthcare Network of PA, Inc.
County of Lehigh - Magellan Behavioral Health of PA, Inc.
County of Montgomery - Magellan Behavioral Health
County of Northampton - Magellan Behavioral Health of PA, Inc.
County of Perry - Community Behavioral Healthcare Network of PA, Inc.
County of Philadelphia - Community Behavioral Health,Inc.
County of Washington - Value Behavioral Health of PA
County of Westmoreland - Value Behavioral Health of PA
County of York - Community Care Behavioral Health
Gateway Health Plan, Inc.
Health Partners of Philadelphia
Keystone Mercy Health Plan
Three Rivers Health Plans, Inc. / MedPLUS
UPMC Health Plan, Inc./UPMC for You
Value Behavioral Health of PA (Greene County)

ADDITIONAL INFORMATION

Special Needs Children: (state defined) Broadly defined, non-categorical to include all children.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

-Provider Data

Consumer Self-Report Data

-CAHPS
  3.0H adult and children
-Consumer/Family Satisfaction Team Survey

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

PENNSYLVANIA
HealthChoices

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Beta-blocker treatment after heart attack
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Cholesterol screening and management
-Controlling high blood pressure
-Dental services
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Health Status/Outcomes Quality
-Patient satisfaction with care

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

PENNSYLVANIA
HealthChoices

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Multiple, but not all, MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics

-Adult/Children access to dental care

Clinical Topics

-Adolescent Pregnancy
-Child/Adolescent Dental Screening and Services
-Smoking prevention and cessation

Standards/Accreditation

MCO/PIHP/PAHP Standards

-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NAIC (National Association of Insurance Commissioners) Standards

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-IPRO

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities

-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of encounter data

TEXAS

* Lonestar Select I

CONTACT INFORMATION

State Medicaid Contact:

Doug Odle
Texas Health & Human Services Commission
(512) 794-5167

State Website Address:

www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area:
Metropolitan Statistical Areas

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 01, 1994

Implementation Date:
September 01, 1994

Waiver Expiration Date:
September 03, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

LoneSTAR Select I is the program that enables the State of Texas to selectively contract with general acute care hospitals including childrens hospitals for inpatient services.Under selective contracting arrangements, providers must bid a discount from their Medicaid reimbursement rates.Then, the State of Texas accepts or negotiates those bids so that qualified providers may serve the Medicaid population for a period of three years.

TEXAS

* Lonestar Select II

CONTACT INFORMATION

State Medicaid Contact:

Doug Odle
Texas Health & Human Services Commission
(512) 794-5167

State Website Address:

www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area:
Metropolitan Statistical Areas

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Solely Reimbursement Arrangement:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
March 10, 1995

Implementation Date:
March 10, 1995

Waiver Expiration Date:
March 04, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

ADDITIONAL INFORMATION

Lonestar Select II is a program that enables the State of Texas to selectively contract with freestanding psychiatric facilities for inpatients services to children. Under Lonestar Select II, providers must bid all inclusive per diem rates for Medicaid reimbursement. The State of Texas then either accepts or negotiates those rates so that providers may serve the under 21 Medicaid population for a period of three years.

TEXAS
NorthSTAR

CONTACT INFORMATION

State Medicaid Contact:

Dena Stoner
Texas Health and Human Services Commision
(512) 424-6500

State Website Address:

http://www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
Maximus Incorporated

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
November 01, 1999

Implementation Date:
November 01, 1999

Waiver Expiration Date:
November 05, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

SERVICE DELIVERY

MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:
Assertive Community Treatment Team, Crisis, Detoxification, Dual Diagnosis, Inpatient Mental Health, Inpatient Substance Use Disorders, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders, Residential Substance Use Disorders Treatment Programs, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCP

Enrollment

TEXAS
NorthSTAR

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
- Qualified Medicare Beneficiaries
- Other Insurance
- Reside in Nursing Facility or ICF/MR
- Children in Protective Foster Care
- Individuals Residing Outside of the Service Region
- Individuals Eligible as Medically Needy
- Individuals Receiving Inpatient Medicaid IMD Services

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Local School Districts
- Mental Health Agency
- Protective and Regulatory Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ValueOptions

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- Consumer Self-Report Data (see below for details)
- Encounter Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PIHP/PAHP Standards (see below for details)
- Monitoring of MCO/PIHP/PAHP Standards
- Ombudsman
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data
- Contract Standard Compliance
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

TEXAS
NorthSTAR

Consumer Self-Report Data
-Modified MHSIP survey

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Depression management
-Follow-up after hospitalization for mental illness

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Number and types of providers
-Time Distance to Providers

Use of Services/Utilization
-Drug Utilization
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan

Health Plan/ Provider Characteristics
-Behavioral Health Specialty Network

-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics
None

Clinical Topics
-Coordination of primary and behavioral health care

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-NCQA Standards for Treatment Records

Accreditation for Deeming
None

EQRO Organization
-QIO-like entity

Accreditation Required for Participation
None

EQRO Name
-Institute for Child Health Policy (ICHP)

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct of performance improvement projects
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

TEXAS
STAR

CONTACT INFORMATION

State Medicaid Contact:

Jason Cooke
Texas Health and Human Services Commission
(512) 424-6539

State Website Address:

http://www.hhsc.state.tx.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
August 01, 1993

Implementation Date:
August 01, 1993

Waiver Expiration Date:
August 31, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Physician Assistants
-Nurse Practitioners

TEXAS
STAR

Enrollment

Populations Voluntarily Enrolled:
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
- Reside in Nursing Facility or ICF/MR
- Medicare Dual Eligible
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- TITLE XXI SCHIP

Lock-In Provision:
No lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
- Federally Qualified Health Centers (FQHCs)
- Rural Health Centers (RHCs)
- Nurse Practitioners
- Obstetricians/Gynecologists
- Nurse Midwives
- Indian Health Service (IHS) Providers
- Other Specialists Approved on a Case-by-Case Basis
- Physician Assistants
- Pediatricians
- General Practitioners
- Family Practitioners
- Internists

Enrollment

Populations Voluntarily Enrolled:
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- Medicare Dual Eligible

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- TITLE XXI SCHIP

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Mental Health Agency
- Public Health Agency

-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Texas
Community Health Choice
First Care
JPS Star
Superior Health Plan
Texas Health Network - Birch & Davis (STAR)
Community First
El Paso First Premier
HMO Blue - STAR
Parkland Community Health Plan
Texas Children's Health Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Child Medicaid AFDC Questionnaire
  Child Medicaid SSI Questionnaire

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-Behavioral health layout
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Preparing HEDIS and risk adjustment software

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamdyia screening in women
-Dental services
-Depression management/care
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Pregnancy Prevention
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care

-Adult's access to preventive/ambulatory health services
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Health Plan/ Provider Characteristics
-Languages Spoken (other than English)
-Provider turnover

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-Multiple, but not all, MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Clinical Topics
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Post-natal Care
-Pre-natal care
-Well Child Care/EPSDT

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS Quality Assessment and Performance Improvement (QAPI) Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-QIO-like entity

Accreditation Required for Participation
None

EQRO Name
-Institute for Child Health Policy, University of Florida

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data
-Validation of performance improvement projects

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

None

Use of Collected Data:

-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling

Performance Measures

Process Quality

-Check-ups after delivery
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Well-child care visit rates in first 15 months of life

Access/Availability of Care

-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager

Provider Characteristics

-Provider turnover

Health Status/Outcomes Quality

-Patient satisfaction with care

Use of Services/Utilization

-Emergency room visits/1,000 beneficiary

Beneficiary Characteristics

-Disenrollment rate
-Information of beneficiary ethnicity/race

Performance Improvement Projects

Clinical Topics

-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics

None

UTAH

Choice Of Health Care Delivery

CONTACT INFORMATION

State Medicaid Contact:

Julie Olson
Utah State Health Department
(801) 538-6358

State Website Address:

http://health.utah.gov/medicaid

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
March 23, 1982

Implementation Date:
July 01, 1982

Waiver Expiration Date:
October 21, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP (non-risk, comprehensive) - Fee-for-Service

Service Delivery

Included Services:
Case Management, Diabetes self-management, Durable Medical Equipment, Enhanced Services to Pregnant Women, EPSDT, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Private Duty Nursing, Skilled Nursing Facility (less than 30 days), Speech Therapy, Vision, Well-adult care, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

UTAH

Choice Of Health Care Delivery

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Pregnant Women
-Medically Needy Children and Adults
-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)
-During Retroactive Eligibility Period
-If Approved as Exempt from Mandatory Enrollment

Lock-In Provision:
1 month lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Nurse Midwives
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Individuals who qualify for Medicaid by paying a spenddown and are aged or disabled
-Special Needs Children (State defined)
-Pregnant Women
-Individuals who qualify for Medicaid by paying a spenddown and are under age 19

Subpopulations Excluded from Otherwise Included Populations:
-Section 1931 non-pregnant adults age 19 and older and related poverty level populations
-Individuals age 19 and older who quality for Medicaid by paying a spenddown and who are not aged or disabled
-Individuals residing in the Utah State Hospital of the Utah Developmental Center
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months
-Have an eligibility period that is only retroactive

Lock-In Provision:
1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Use fee-for-service claims to idenfify members who received a carve-out service such as Early Intervention
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Aging Agency
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Substance Abuse Agency
- Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Healthy U
Molina Healthcare of Utah (AFC UTAH)
IHC Health Plans Inc.

ADDITIONAL INFORMATION

A child under 21 who has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who, consistent with 1932(a)(2)(A) of the Act, 42 U.S.C., Section 1936u-2(a)(2)(A).

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
- Enrollee Hotlines
- On-Site Reviews
- Performance Measures (see below for details)
- Provider Data

Consumer Self-Report Data
None

Use of Collected Data:
- Contract Standard Compliance

Performance Measures

Process Quality
None

Access/Availability of Care
- Ratio of primary care case managers to beneficiaries

Health Status/Outcomes Quality
None

Use of Services/Utilization
- Emergency room visits/1,000 beneficiaries

UTAH
Choice Of Health Care Delivery

Provider Characteristics
-Board Certification
-Languages spoken (other than English)

Beneficiary Characteristics
None

UTAH
Non-Emergency Transportation

CONTACT INFORMATION

State Medicaid Contact:

Don Hawley
Utah State Department of Health
(801) 538-6483

State Website Address: http://health.utah.gov/medicaid

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
September 19, 2000

Implementation Date:
July 01, 2001

Waiver Expiration Date:
September 18, 2004

Sections of Title XIX Waived:
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Transportation PAHP - Full Capitation

Service Delivery

Included Services:
Non-Emergency Transportation

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Pregnant Women
-Special Needs Children (State defined)
-Special Needs Children (BBA defined)

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Reside in the State Hospital or in the State Developmental Center

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Non-Emergency Transportation

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-Enrollee Hotlines
-Monitoring of MCO/PIHP/PAHP Standards

Consumer Self-Report Data
None

Use of Collected Data
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Use of HEDIS
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
None

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted

UTAH
Non-Emergency Transportation

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Independent accounting firm

EQRO Organization
-Independent cost-effectiveness study

EQRO Mandatory Activities
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities
-Validation of client level data, such as claims and encounters

UTAH

Prepaid Mental Health Program

CONTACT INFORMATION

State Medicaid Contact:

Karen Ford
Utah State Health Department
(801) 538-6637

State Website Address:

http://www.health.state.ut.us/Medicaid

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
July 01, 1991

Implementation Date:
July 01, 1991

Waiver Expiration Date:
December 26, 2005

Sections of Title XIX Waived:
- -1902(a)(1) Statewideness
- -1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Full Capitation

Service Delivery

Included Services:
Crisis, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Transportation

Contractor Types:
- -CMHC Operated Entity (Public)
- -County Operated Entity (Public)
- -CMHC - some private, some governmental

Allowable PCPs:
- -Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations
- -Pregnant Women

-Foster Care (inpatient services only)

Subpopulations Excluded from Otherwise Included Populations:
-Resident of the Utah State Hospital (IMD)
-Resident of the State Developmental Center (DD/MR facility)
-Title XXI CHIP

Lock-In Provision:
1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Use fee-for-service claims data to identify clients received Early Intervention services
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Public Health Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bear River Mental Health
Davis Mental Health
Northeastern Counseling Center
Valley Mental Health
Weber Mental Health
Central Utah Mental
Four Corners Mental Health
Southwest Mental Health
Wasatch Mental Health

ADDITIONAL INFORMATION

Community Mental Health Centers serve as Prepaid Mental Health Plans to provide/coordinate all mental health services in 9 of Utahs 10 mental health service areas.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data
-State-developed Survey

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Use of HEDIS
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the

HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Continuity of Care
-Symptom reduction

Access/Availability of Care
-Average time for intake
-Use of Services/Utilization

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net worth
-State minimum reserve requirements

Beneficiary Characteristics
-Information of beneficiary ethnicity/race

Health Status/Outcomes Quality
-Patient satisfaction with care
-Racidivism
-Symptom reduction

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics
-Languages Spoken (other than English)

-Information on age and gender
-Information on primary languages spoken by beneficiaries

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards

-State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

-In-house

Accreditation Required for Participation

None

EQRO Name

-State of Utah

EQRO Mandatory Activities

-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

VIRGINIA
MEDALLION

CONTACT INFORMATION

State Medicaid Contact:	Alissa Nashwinter Department of Medical Assistance Services (804) 225-4714
State Website Address:	http://www.dmas.state.va.us/

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
MAXIMUS, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 23, 1991

Implementation Date:
March 01, 1992

Waiver Expiration Date:
March 24, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

VIRGINIA
MEDALLION

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Subsidized Adoption
-Refugees
-Spenddown
-Hospice
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Initial Interview with Enrollees
-Reviews claims activity of a new enrollees for special indicators
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agencies
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medallion

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation

VIRGINIA
MEDALLION

Child Medicaid SSI Questionnaire
Child with Special Needs Questionnaire

VIRGINIA
Medallion II

CONTACT INFORMATION

State Medicaid Contact:	Mary Mitchell Department of Medical Assistance Services (804) 786-3594
State Website Address:	http://www.dmas.state.va.us/

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(4)

Enrollment Broker:
MAXIMUS, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
December 18, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 25, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

VIRGINIA
Medallion II

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligible
- Other Insurance
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- Eligibility Less Than 3 Months
- Hospice

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Asks advocacy groups to identify members of these groups
- Initial interviews with new enrollees
- Review claims activity of all new enrollees for special indicators
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Education Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

CareNet
Peninsula Health Care, Inc.
Sentara Family Care
Virginia Premier
HealthKeepers Plus, Inc.
Priority Health Care, Inc.
Unicare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- Encounter Data (see below for details)
- Focused Studies
- On-Site Reviews
- Performance Measures (see below for details)

Use of Collected Data
- Fraud and Abuse
- Health Services Research
- Monitor Quality Improvement
- Plan Reimbursement
- Program Evaluation
- Track Health Service provision

VIRGINIA
Medallion II

Consumer Self-Report Data
None

Use of HEDIS
-The State uses ALL of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Access/Availability of Care
-Average distance to PCP
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care
-Days cash on hand

Health Status/Outcomes Quality
None

Use of Services/Utilization
None

Health Plan/ Provider Characteristics
-Board Certification

- -Days in unpaid claims/claims outstanding
- -Medical loss ratio
- -Net income
- -Net worth
- -Total revenue

Beneficiary Characteristics

- -Information of beneficiary ethnicity/race
- -MCO/PIHP/PAHP/PCP-specific disenrollment rate
- -Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs

- -Languages Spoken (other than English)

Standards/Accreditation

MCO/PIHP/PAHP Standards

None

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-Delmarva

EQRO Mandatory Activities

-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities

- -Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
- -Validation of client level data, such as claims and encounters

WASHINGTON

Healthy Options

CONTACT INFORMATION

State Medicaid Contact:

MaryAnne Lindeblad
Division of Program Support
(360) 725-1786

State Website Address:

http://www.dshs.wa.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 01, 1993

Implementation Date:
October 01, 1993

Waiver Expiration Date:
July 01, 2003

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:

None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Physician Assistants

Enrollment

WASHINGTON
Healthy Options

Populations Voluntarily Enrolled:
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Pregnant Women and Optional Children

Subpopulations Excluded from Otherwise Included Populations:
- -Enrolled in Another Managed Care Program
- -Participate in HCBS Waiver
- -American Indian/Alaskan Native
- -Retroactive Eligibility
- -Reside in Nursing Facility or ICF/MR
- -Medicare Dual Eligible

Populations Mandatorily Enrolled:
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Pregnant Women and Optional Children

Lock-In Provision:
No lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

Allowable PCPs:
- -Obstetricians/Gynecologists
- -Federally Qualified Health Centers (FQHCs)
- -Rural Health Centers (RHCs)
- -Nurse Practitioners
- -Nurse Midwives
- -Indian Health Service (IHS) Providers
- -Physician Assistants
- -Pediatricians
- -General Practitioners
- -Family Practitioners
- -Internists

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- -Enrolled in Another Managed Care Program
- -Participate in HCBS Waiver
- -Retroactive Eligibility
- -Medicare Dual Eligible
- -Reside in Nursing Facility or ICF/MR

Populations Mandatorily Enrolled:
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Pregnant Women and Optional Children

Lock-In Provision:
No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Asuris Northwest Health
Columbia United Providers
Group Health
Molina
Regence Blue Shield

BHP Plus
Community Health Plans of Washington
Healthy Options/PCCM
Premera Blue Cross

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Provider ID
-Type of Service

Collections: Submission Specifications

-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Required use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments

Yes

-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure

Performance Measures

Process Quality

-Breast Cancer screening rate
-Check-ups after delivery
-Diabetes management/care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics

-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics

-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics

-Childhood Immunization
-Well Child Care/EPSDT

Non-Clinical Topics

-Adults access to preventive/ambulatory health services

Standards/Accreditation

WASHINGTON

Healthy Options

MCO/PIHP/PAHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-OMPRO

EQRO Mandatory Activities
-Validation of performance improvement projects

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Enrollee Hotlines

Consumer Self-Report Data
None

Use of Collected Data:
-Program Evaluation

WASHINGTON

The Integrated Mental Health Services

CONTACT INFORMATION

State Medicaid Contact:	Judy Gosney Mental Health Divison (360) 902-0827
State Website Address:	http://www1.dshs.wa.gov/mentalhealth

PROGRAM DATA

Program Service Area:
County
Region

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
April 27, 1993

Implementation Date:
July 01, 1993

Waiver Expiration Date:
March 04, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(4) - Mandate Enrollees Into Single PIHP

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PIHP - Full Capitation

Service Delivery

Included Services:
Crisis, EPSDT, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Rehabilitation Case Management

Contractor Types:
-Regional Authority Operated Entity (Public)

Allowable PCPs:
-Service Providers Under This Waiver Do Not Meet PCP Definition

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

WASHINGTON
The Integrated Mental Health Services

-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Reside in Nursing Facility or ICR/MR
-Other Insurance

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Residents of State-owned institutions
-Pregnant Women included in Family Planning Waiver
-Homeless People not Enrolled in Medicaid

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-All Persons Meet SCHN

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Employment Agency
-Housing Agency
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Chelan/Douglas Regional Support Network
Grays Harbor Regional Support Network
King County Regional Support Network
North Sound Regional Support Network
Peninsula Regional Support Network
Southwest Regional Support Network
Thurston/Mason Regional Support Network
Clark County Regional Support Network
Greater Columbia Regional Support Network
North Central Washington Regional Support Network
Northeast Washington Regional Support Network
Pierce County Regional Support Network
Spokane County Regional Support Network
Timberland Regional Support Network

ADDITIONAL INFORMATION

Due to the nature of the waiver which is for a limited segment of services, the program does designate a primary care provider. Individuals choose their own providers. Pregnant women in the Basic Health program (state funded program) are excluded from the Mental Health program.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse

WASHINGTON
The Integrated Mental Health Services

-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Measures (see below for details)
-Quality Review Team
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
-"MHSIP CHILD, FAMILY AND ADULT SURVEY"
-Consumer/Beneficiary Focus Groups

Use of HEDIS
-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Performance Measures

Process Quality
None

Access/Availability of Care
-Access to Appointment
-Availability of MHPs
-Average Distance to Service

Health Plan Stability/ Financial/Cost of Care
None

Beneficiary Characteristics
None

Health Status/Outcomes Quality
None

Use of Services/Utilization
-Crisis Contacts
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Outpatient Mental Health Hours

Health Plan/ Provider Characteristics
None

Standards/Accreditation

MCO/PIHP/PAHP Standards
-16 state pilot indicator project
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-State Mental Health Authority

Accreditation Required for Participation
None

EQRO Name
-Does not Apply

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

WEST VIRGINIA
Mountain Health Trust

CONTACT INFORMATION

State Medicaid Contact:	Shelley Baston Office of Managed Care, Bureau for Medical Service (304) 558-5978
State Website Address:	http://www.wvdhhr.org

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(4)

Enrollment Broker:
Automated Health Systems, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 29, 1996

Implementation Date:
September 01, 1996

Waiver Expiration Date:
March 22, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Obstetricians/Gynecologists
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Internists
-Nurse Practitioners

Enrollment

WEST VIRGINIA
Mountain Health Trust

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medically Needed

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:
1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carelink Health Plan

Health Plan of the Upper Ohio Valley

ADDITIONAL INFORMATION

Reason for multiple enrollment for Children and Related populations and Adults and Related populations: In counties with only one MCO, clients can choose to remain in the PCCM program.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Complaints, grievances and disenrollment data
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

WEST VIRGINIA
Mountain Health Trust

Consumer Self-Report Data
-Disenrollment Survey
-State-developed Survey
-State-developed Survey of Children with Special Health Needs

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-NSF (National Standard Format)
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management/care

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

- -Frequency of on-going prenatal care
- -Hearing services for individuals less than 21 years of age
- -Immunizations for two year olds
- -Initiation of prenatal care - timeliness of
- -Lead screening rate
- -Smoking prevention and cessation
- -Vision services for individuals less than 21 years of age
- -Well-child care visit rates in first 15 months of life
- -Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care

- -Average distance to PCP
- -Ratio of PCPs to beneficiaries

Use of Services/Utilization

- -Days/1000 and average length of stay for IP administration, ER visits, Ambulatory surgery, maternity care, newborn care
- -Emergency room visits/1,000 beneficiary
- -Inpatient admissions/1,000 beneficiary
- -Number of home health visits per beneficiary
- -Number of OB/GYN visits per adult female beneficiary
- -Number of PCP visits per beneficiary
- -Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of Care

- -Actual reserves held by plan
- -Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- -Medical loss ratio
- -Net income
- -Net worth
- -State minimum reserve requirements
- -Total revenue
- -Total Third Party Liability Collections Made By Source

Health Plan/ Provider Characteristics

- -Board Certification
- -Provider turnover

Beneficiary Characteristics

- -Information of beneficiary ethnicity/race
- -Information on primary languages spoken by beneficiaries
- -MCO/PIHP/PAHP/PCP-specific disenrollment rate
- -Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
- -Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

- -MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
- -All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics

None

Clinical Topics

- -Coordination of care for persons with physical disabilities
- -Post-natal Care

Standards/Accreditation

MCO/PIHP/PAHP Standards

- -CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
- -JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
- -NAIC (National Association of Insurance

Accreditation Required for Participation

None

Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards
-QARI (Quality Assurance Reform Initiative) Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Name
-Delmarva

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Sentinel Event Review
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

WEST VIRGINIA

Physician Assured Access System

CONTACT INFORMATION

State Medicaid Contact:

Shelley Baston
Office of Managed Care, Bureau for Medical Service
(304) 558-5978

State Website Address:

http://www.wvdhhr.org

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b) - Waiver Program

Statutes Utilized:
1915(b)(1)
1915(b)(2)

Enrollment Broker:
Automated Health Systems, Inc.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
August 29, 1991

Implementation Date:
June 01, 1992

Waiver Expiration Date:
April 27, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

-Foster Care Children

-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Other Insurance

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Physician Assured Access System

ADDITIONAL INFORMATION

The PAAS Program operates soley in counties not covered by an HMO. In counties with HMO coverage, The PAAS Program operates as the second managed care program. The PAAS Program is not a choice when there are two HMOs in a county. The state granted one year eligibility for any child, under the age of 19, who is eligible for Medicaid, beginning June 1, 2001.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-State-developed Survey

Use of Collected Data:

-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting

Performance Measures

Process Quality

-Adolescent immunization rate
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate

Health Status/Outcomes Quality

-Patient satisfaction with care

-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care
-Average distance to primary care case manager
-Ratio of primary care case managers to beneficiaries

Provider Characteristics
-Languages spoken (other than English)

Use of Services/Utilization
-Drug Utilization
-Emergency room visits
-Inpatient admissions
-Number of primary care case manager visits per beneficiary

Beneficiary Characteristics
None

Section:
Concurrent 1915(b)/1915(c) Waiver Programs

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MICHIGAN
Specialty Prepaid Inpatient Health Plans

CONTACT INFORMATION

State Medicaid Contact:	Judy Webb MDCH, Division of Quality Management and Planning (517) 335-4419
State Website Address:	http://www.mdch.michigan.gov

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
June 26, 1998

Implementation Date:
October 01, 1998

Waiver Expiration Date:
December 09, 2003

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Developmentally Disabled, MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:
Crisis, Durable Medical Equipment, Emergency Specialty DD, Home Health, Inpatient Mental Health, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, MH Clinic, Outpatient Mental Health (Partial Hospitalization), Outpatient Substance Use Disorders, Personal Care, Residential Substance Use Disorders Rehabilitation, Specialty Services and Supports for persons with DD, Targetted Case Management, Transportation

Contractor Types:
-County Community Mental Health Services

Allowable PCPs:
-Psychiatrists
-Psychologists
-Clinical Social Workers
-Addictionologists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

MICHIGAN

Specialty Prepaid Inpatient Health Plans

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Residing in ICF/MR
-Children Enrolled in Childrens Waiver (Section 1915(c))

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Identified through other health care agencies
-Outreach
-Referred through other health care practitioners/agencies
-Self-referral

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Education Agency
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Specialty Employment Agency (Supported Employment)
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bay Arenac CMH
Central Michigan CMH
Genesee County Health Department
Kent County CMH
Macomb County CMH
North Central CMH
Oakland County CMHA
Saginaw County CMH
Summit Point CMH
CEI CMH
Detroit-Wayne CMH
Kalamazoo County CMH
Lifeways CMH
Muskegon County CMH
Northern Michigan CMH
Pathways CMH
St. Clair County CMH
Washtenaw County CMH

ADDITIONAL INFORMATION

Michigan remains one of the very few, if not the only, state to have incorporated services to persons with Developmental Disabilities into a 1915(b) Freedom of Choice "managed care" waiver. Also, all persons adjudicated Medicaid eligible are deemed enrolled in this Specialty Community Mental Health Services and Supports managed care program.

Concurrent Operating 1915(c) Program

MICHIGAN

Specialty Prepaid Inpatient Health Plans

CONTACT INFORMATION

State Medicaid Agency Contact:	Judy Webb Director, Division of Quality Management and Plann Michigan Department of Community Health 517 335-4419
State Operating Agency Contact:	Debra Ziegler HSW Specialist Bureau of Community Health Services Michigan Department of Community Health (517) 241-3044

PROGRAM DATA

Program Service Area:
Statewide

Statutes Waived:
1902(a)(10)(B) Comparability of Services

Initial Waiver Approval Date:
October 02, 2000

Implementation Date:
October 01, 2000

Waiver Expiration Date:
September 30, 2005

Service Delivery

Target Group:
Developmental Disabled

Level of Care:
ICFMR

ADDITIONAL INFORMATION

Under the Michigan Managed Specialty Support and Services Program, PIHPs administer state plan alternatives and 1915(c) waiver services. This managed mental health services program provides supports and services to persons with serious mental illness, developmental disability and substance use disorders, and children with serious emotional disturbance. Persons served through the B waiver use a combination of state plan and alternative services. Persons enrolled in the C waiver, called the Habilitation Supports Waiver (HSW), use a combination of C waiver services, state plan, and alternative services.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- -Accreditation for Participation (see below for details)
- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -MCO/PIHP/PAHP Standards (see below for details)
- -Monitoring of MCO/PIHP/PAHP Standards
- -On-Site Reviews

Use of Collected Data
- -Actuarial analysis
- -Contract Standard Compliance
- -Health Services Research
- -Monitor Quality Improvement
- -Program Evaluation
- -Regulatory Compliance/Federal and State Reporting

-Performance Measures (see below for details)

-Track Health Service provision

Consumer Self-Report Data
-MHSIP Consumer Survey

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of electronic file formats
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Provider ID
-Type of Service
-Medicaid Eligibility
-Diagnosis Codes
-Age-appropriate diagnosis/procedure
-Age
-Gender
-Race/Ethnicity
-Social Security

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Follow-up after hospitalization for mental illness
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality
-Adults living in homes of their own
-Adults working in supported employment
-Children living with family
-Patient satisfaction with care
-Rates of rights complaints/1000 served
-Rates of sentinel events/1000 served
-Rates of suicide/1000 served

Access/Availability of Care
-Average wait time for first appointment with PCP
-Penetration rates for special populations
-Percent of denials of service
-Percent of persons in NH's who met OBRA criteria, served

Use of Services/Utilization
-Cost per case by population
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility

-Wait time for commencement of service(s)

-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care
None

Beneficiary Characteristics
None

Health Plan/ Provider Characteristics
None

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
-CARF
-COA
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-The Council

EQRO Name
-Michigan Peer Review Organization

EQRO Mandatory Activities
-Validation of performance measures

EQRO Optional Activities
-Clinical Record Review

TEXAS
STAR+PLUS

CONTACT INFORMATION

State Medicaid Contact:	Pam Coleman Health and Human Services Commission (512) 685-3172
State Website Address:	http://www.hhsc.state.tx.us/starplus/starplus.htm

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Maximus

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 30, 1998

Implementation Date:
February 01, 1998

Waiver Expiration Date:
August 31, 2004

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Internists
-Physician Assistants
-Nurse Practitioners
-Nurse Midwives
-Rural Health Clinics (RHCs)
-Federally Qualified Health Centers (FQHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
- Aged and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
- Reside in Nursing Facility or ICF/MR
- Poverty Level Pregnant Woman
- Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Substance Use Disorders, Physician, X-Ray

Allowable PCPs:
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Nurse Midwives
- Physician Assistants
- Other Specialists Approved on a Case-by-Case Basis
- Pediatricians
- General Practitioners
- Family Practitioners
- Internists
- Obstetricians/Gynecologists
- Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
- Poverty Level Pregnant Woman
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- DOES NOT coordinate with any other Agency

TEXAS
STAR+PLUS

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup- STAR+PLUS	HMO Blue
Texas Health Network - Birch & Davis	

ADDITIONAL INFORMATION

None

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Bill Farnsowth
Policy & Information Specialist
Health & Human Services Commission
512-491-1301

State Operating Agency Contact:

Not Applicable

PROGRAM DATA

Program Service Area:
County

Statutes Waived:
1902(a)(1) Statewideness
1902(a)(10)(B) Comparability of Services

Initial Waiver Approval Date:
February 01, 1998

Implementation Date:
January 01, 1998

Waiver Expiration Date:
August 31, 2005

Service Delivery

Target Group:
Aged and Disabled

Level of Care:
Nursing Home

ADDITIONAL INFORMATION

Both b&c waivers are operating through the STAR+PLUS program which integrates acute and long term care services for SSI enrollees in Harris County.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-On-Site Reviews
-Provider Data

Use of Collected Data
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
-State-developed Survey

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Institute for Child Health Policy

EQRO Organization
-QIO-like entity

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities
None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-On-Site Reviews

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal

Consumer Self-Report Data
None

WISCONSIN

Family Care

CONTACT INFORMATION

State Medicaid Contact:

Charles Jones
Wisconsin Department of Health and Family Services
(608) 266-0991

State Website Address:

http://www.dhfs.state.wi.us/LTCare/INDEX.HTM

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1915(b)/1915(c)

Statutes Utilized:
1915(b)(1)
1915(b)(2)
1915(b)(3)
1915(b)(4)

Enrollment Broker:
Southeastern Wisconsin Area Agency on Aging

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
June 01, 2001

Implementation Date:
January 01, 2002

Waiver Expiration Date:
December 31, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30) Upper Payment Limit
-1902(a)(4) Choice of PIHP

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

LTC PIHP - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, Home Health, Inpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Skilled Nursing Facility, Transportation

Allowable PCPs:
-Not applicable, primary care is carved out

Enrollment

WISCONSIN
Family Care

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Have an Eligibility Period that Is Only Retroactive
-Under Age 60 in Milwaukee County

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-All Target Groups Are Persons with Special Needs

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Developmental Disabilities Agency
-Education Agency
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Family Care

ADDITIONAL INFORMATION

Milwaukee County Department of Aging serves only persons age 60 and over

Concurrent Operating 1915(c) Program

CONTACT INFORMATION

State Medicaid Agency Contact:

Charles Jones
Lead Waiver/Policy Analyst
Department of Health and Family Services
(608) 266-0991

State Operating Agency Contact:

Not Applicable

PROGRAM DATA

Program Service Area:
County

Initial Waiver Approval Date:
June 01, 2001

WISCONSIN
Family Care

Statutes Waived:

1902(a)(1) Statewideness
1902(a)(10)(B) Comparability of Services
1902(a)(10)(C)(i)(III) Income and Resource Rules

Implementation Date:

January 01, 2002

Waiver Expiration Date:

December 31, 2004

Service Delivery

Target Group:

Aged and Disabled
Mentally Retarded and Developm

Level of Care:

Nursing Home
ICFMR

ADDITIONAL INFORMATION

Family Care is a capitated, full risk managed care program for the delivery of long-term care services. Family Care 1915b Long Term Care PIHP, which includes 1915c waiver services and Medicaid State Plan Long Term Care services. Primary and acute health care are carved out, but remain available to enrollees through the Medicaid State. Every enrollee participates with an interdisciplinary care management team that, at minimum includes a nurse and a social worker, in a member-centered planning process to design an individualized service plan (ISP). The ISP is designed to identify the members long-term care needs and authorize services to achieve identified outcomes in relation to those needs. PIHP quality is evaluated on a performance-based QA/QI assessment of success in meeting identified outcomes. The assessment methodology uses: 1) a structured validated member interview tool to eveluate member perception of performance; 2) a structured review of a sample of ISPs by the States External Quality Review Organization; 3) annual State evaluation and certification of the PIHP network of providers to ensure adequate access and capacity; and 4) ongoing utlilization review and focus studies to identify areas for performance improvement projects and other quality improvement strategies. Aging and Disability Resource Centers are established in each county where Family Care is available to act as a single entry point for information and access to services for persons in need of long-term care

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-Individualized Service Plan Reviews
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Structured Member Outcome Interviews

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation

Consumer Self-Report Data

-Structured Member Outcome Interviews

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

WISCONSIN
Family Care

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Procedure Codes
-Revenue Codes

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Member LTC outcomes present
-Support for member LTC outcomes provided

Access/Availability of Care
-State assessment of adequate network capacity

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-State minimum reserve requirements

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-MCO/PIHP/PAHP/PCP-specific disenrollment rate

Health Status/Outcomes Quality
-Meber health and safety outcomes present
-Support for member health and safety outcomes provided

Use of Services/Utilization
-NF and ICF-MR utilization

Health Plan/ Provider Characteristics
-Board Certification
-State review for cultural competency

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards

-State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-MetaStar, Inc.

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities

Section:
1115(a) – Demonstration Waiver Programs

This page was not included in the page numbering

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

CONTACT INFORMATION

State Medicaid Contact:

Lynn Dunton
AHCCCS
(602) 417-4447

State Website Address:

http://www.AHCCCS.state.az.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
July 13, 1982

Implementation Date:
October 01, 1982

Waiver Expiration Date:
September 30, 2006

Sections of Title XIX Waived:

-1902(a)(10)((a)(ii)(V) - Hospitalized Individuals
-1902(a)(10)(B) - Supported Employment
-1902(a)(10)(B)(i) - MCO Enrollees
-1902(a)(13) except 1902(a)(13)(A)
-1902(a)(14) - Copays
-1902(a)(17) - Quarterly Income
-1902(a)(18) - Estate Recovery
-1902(a)(23) - Freedom of Choice
-1902(a)(30)
-1902(a)(34) - Prior Quarter
-1902(a)(4) - Reimbursement Arrangements
-1902(a)(54) - Outpatient Drugs

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-1903(i)
-1903(i)(10) Eligibility Expansion, Eligibility Simplification, Family Planning, IMD
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(ix)
-1903(m)(2)(A)(vi)
-1903(m)(2)(A)(viii)
-1903(m)(4)(A)&(B) HCBS

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

Included Services:

Case Management (DDD only), Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing (EPSDT only), Home Health, Hospice (EPSDT only), Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Maternity, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transplantation of Organs and Tissue and Related Immunosuppresant Drugs, Transportation, Vision (EPSDT only), X-Ray

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Indian Health Service (IHS) Providers
-Physician Assistants
-Certified Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Populations Mandatorily Enrolled:

-Families with Dependent Children Under Age 18 (1931) and Continuing Coverage (TMA/CS)
-Pregnant Women (SOBRA)
-Federal Poverty Level Children Under Age 19 (SOBRA)
-Adults Without Minor Children Title XIX Waivers
-Adoption Subsidy Children
-Section 1931 Families with Children and Related Populations
-Title XIX Waiver Spend Down Population
-HIFA Parents
-Foster Care Children
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Lock-In Provision:

12 month lock-in

MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:

Case Management, Crisis, Detoxification, Emergency and Non-emergency Transportation, IMD, Individual Therapy and Counseling, Inpatient Mental Health, Inpatient Psychiatric for Persons Under 21, Inpatient Substance Use Disorders, Laboratory, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders, Pharmacy, Residential Substance Use Disorders Treatment Programs, X-Ray

Allowable PCPs:

-PCP is in Medicaid Health Plan

Enrollment

Populations Voluntarily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-Special Needs Children (State defined)
-Special Needs Children (BBA defined)

Populations Mandatorily Enrolled:

-Foster Care Children
-Families with Dependent Children under age 18 (1931) and Continuing Coverage (TMA/CS)
-Pregnant Women (SOBRA)
-Federal Poverty Level Children Under Age 19 (SOBRA)
-Adults Without Minor Children Title XIX Waiver
-Adoption Subsidy Children
-Section 1931 Families with Children and Related Populations
-Title XIX Waiver Spend Down
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Developmental Disabilities Agency
-Maternal and Child Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AZ Physicians IPA (Family Planning Extension)
CIGNA Community Choice (Family Planning Extension)
Cochise Co. Dept. of Health Services (PC)
AZ Physicians IPA (HP)
CIGNA Community Choice (HP)
Department of Economic Security/Childrens Medical and Dental Program (Family Planning Extension)

ARIZONA

Arizona Health Care Cost Containment System (AHCCCS)

Department of Economic Security/Childrens Medical and Dental Program (HP)
Department of Economic Security/Division of Developmental Disabilities (PC)
Department of Health Services (Behavioral Health)
Evercare Select (PC)
Family Health Plan of North Eastern Arizona (Family Planning Extension)
Family Health Plan of North Eastern Arizona (HP)
Health Choice Arizona (Family Planning Extension)
Health Choice Arizona (HP)
Maricopa County Health Plan (Family Planning Extension)
Maricopa County Health Plan (HP)
Maricopa County Health Plan (PC)
Mercy Care Plan (Family Planning Extension)
Mercy Care Plan (HP)
Mercy Care Plan (PC)
Phoenix Health Plan/Community Connection (Family Planning Extension)
Phoenix Health Plan/Community Connection (HP)
Pima Health System (Family Planning Extension)
Pima Health System (HP)
Pima Health System (PC)
Pinal County Long Term Care (PC)
University Family Care (Family Planning Extension)
University Family Care (HP)
Yavapai County Long Term Care (PC)

ADDITIONAL INFORMATION

A managed care system based on prepaid capitation to health plans and long term care program contractors. Never operated as a fee-for-service program. Arizona contracts with the Arizona Department of Health Services, who in turn contracts with Regional Behavioral Health Authorities (RBHAs) to provide behavioral health services to AHCCCS members.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Dentist Survey
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Physician Survey
-Provider Data
-Quality Improvement Projects (QIPS)
-Quality Management/Quality Improvement Annual Plans and Annual Evaluations

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey
-State-developed Survey

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission

-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Accuracy checks are done on encounter demographic, clinical and financial data elements

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent Well-Care Visits
-Adults' Access to Preventitive/Ambulatory Health Services
-Alzheimers study to evaluate appropriateness of care
-Annual Dental Visits among Children (ages 3 - 20)
-Blood lead screening
-Breast Cancer Screening
-Cervical Cancer Screening
-Children's Access to Primary Care Providers
-Children's Access to Primary Care Providers - KidsCare Population
-Dental Services
-Diabetes Management (ATLCS indicator)
-Health Screenings
-Hearing Services for Individuals less than 21 years of age
-Immunization of 2 year olds
-Influenza Immunizations and Pneumococcal Vaccination Rates in the Elderly and Physically Disabled Population in Nursing Facilities and In Home Community Based Setting (ALTCS indicator)
-Initiation of prenatal care - timeliness of
-Lead Screening Rate
-Low Birth Weight Deliveries
-Number of new Perinatal cases of HIV/AIDS

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

-Patient Satisfaction With Care
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Prenatal Care in the First Trimester
-Timeliness of Initiation of Services (ALTCS Indicator)
-Utilization of Family Planning Services (Internal Report Only)
-Vision services for individuals less than 21 years of age
-Well-child visits at 3,4,5 and 6 years of age
-Well-child visits up to 15 month of age

Access/Availability of Care

-Alzheimer study to evaluate appropriateness of HCBS care
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (i.e., inpatient, ER, Pharmacy, lab, x-ray, dental,vision, etc.)
-Financial Viability Ratios (i.e., Current Ratio, Medical Expense, Administrative, Equity/Member)
-Net income
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics

-Information of beneficiary ethnicity/race
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of home health visits per beneficiary
-Number of PCP visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics

-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements

-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics

-Adolescent Well-Care visits
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Childhood Immunization
-Children@s Access to Primary Care Providers
-Children@s Access to Primary Care Providers - KidsCare populations
-Coordination of primary and behavioral health care
-Diabetes management/care
-Emergency Room service utilization
-HIV Status/Screening
-Hospital Discharge Planning
-Influenza immunizations and Pneumococcal vaccination rates in the Elderly and Physically Disabled population in nursing facilities and home and community based settings
-Low birth-weight baby
-Medical problems of the frail elderly
-Pharmacy management
-Post-natal Care
-Pregnancy Prevention
-Pre-natal care
-Prevention of Influenza

-Timeliness of Initiation of Services
-Well Child Care/EPSDT

Non-Clinical Topics

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Provider education regarding cultural health care needs of members

Standards/Accreditation

MCO/PIHP/PAHP Standards

-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization

Accreditation Required for Participation

None

EQRO Name

-Health Services Advisory Group
-William Mercer

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

CALIFORNIA
Center For Elders Independence

CONTACT INFORMATION

State Medicaid Contact:	Carol Freels DHS (916) 440-7535
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 04, 1995

Implementation Date:
April 01, 1995

Waiver Expiration Date:
November 24, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(a)(23)
-1903(m)(2)(A)(I)(II)

SERVICE DELIVERY

Long Term Care MCO - Full Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

CALIFORNIA
Center For Elders Independence

Subpopulations Excluded from Otherwise Included Populations:
-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Special Needs Children

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Health Fairs, presentations, Senior Groups
-Mass Mailings to Potential Enrollees
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-None

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Centers for Elders Independence

ADDITIONAL INFORMATION

If the potential participant meets the eligibility requirements for enrollment into the PACE program, which is 55 years and older, lives in the plans approved service area, and is certified for nursing facility level of care and elects to enroll in the PACE program, the participant will remain enrolled in the program unless he or she chooses to voluntarily disenroll from the plan or is involuntarily disenrolled by the plan with DHS approval.

The program provides a full continuum of medical, social and long term care services to nursing home eligibles age 55 and over who live in a specifica geographic area.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Does not Collect Quality Data

Use of Collected Data
-Not Applicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

Center For Elders Independence

EQRO Organization
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
None

CALIFORNIA

On Lok Senior Health Services

CONTACT INFORMATION

State Medicaid Contact:	Carol Freels DHS (916) 440-7535
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
November 01, 1983

Implementation Date:
November 01, 1983

Waiver Expiration Date:
November 24, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(f)(4)(C)
-1903(m)(A)(I)(II)

SERVICE DELIVERY

Long Term Care MCO - Full Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

CALIFORNIA
On Lok Senior Health Services

Subpopulations Excluded from Otherwise Included Populations:

-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Special Needs Children

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Health Fairs, presentations Senior Groups
-Mass Mailings to Potential Enrollees
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

On Lok

ADDITIONAL INFORMATION

If the potential participant meets the eligibility requirements for enrollment into the PACE program, which is 55 years and older, lives in the plans approved service area, and is certified for nursing facility level of care and elects to enroll in the PACE program, the participant will remain enrolled in the program unless he or she chooses to voluntarily disenroll from the plan or is involuntarily disenrolled by the plan with DHS approval.

This program provides a full continuum of medical, social and long term care services to nursing home eligibles age 55 and over who live in a specific geographic area.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Does Not Collect Quality Data

Use of Collected Data

-Not Applicable

Consumer Self-Report Data

None

Use of HEDIS

-Not Applicable

Standards/Accreditation

MCO/PIHP/PAHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Not Applicable

CALIFORNIA
On Lok Senior Health Services

EQRO Organization
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
None

CALIFORNIA
Senior Care Action Network

CONTACT INFORMATION

State Medicaid Contact:	Carol Freels DHS (916) 440-7535
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
June 07, 1985

Implementation Date:
January 01, 1985

Waiver Expiration Date:
December 31, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(e)(2)(A)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-None

SERVICE DELIVERY

Social HMO - Full Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Chiropractic Care, Dental, Durable Medical Equipment, Emergency Care, Health Education, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Mental Health, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Speach Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

CALIFORNIA
Senior Care Action Network

-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Special Needs Children

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Senior Care Action Network

ADDITIONAL INFORMATION

SCAN eligibility requires the beneficiary to be dually eligible, over 65 and for long term care benefits must meet the criteria for skilled or intermediate nursing care. SCAN is the only social HMO in California.

This program provides medical, social and limited long term care services.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Does Not Collect Quality Data

Use of Collected Data

-Not Applicable

Consumer Self-Report Data

None

Use of HEDIS

-Not Applicable

Standards/Accreditation

MCO/PIHP/PAHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Not Applicable

CALIFORNIA
Senior Care Action Network

EQRO Organization
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
None

CALIFORNIA
Sutter Senior Care

CONTACT INFORMATION

State Medicaid Contact:	Carol Freels DHS (916) 440-7535
State Website Address:	http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 14, 1994

Implementation Date:
May 01, 1994

Waiver Expiration Date:
November 24, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(f)(4)(c)
-1903(m)(2)(A)(I)(II)

SERVICE DELIVERY

Long Term Care MCO - Full Capitation

Service Delivery

Included Services:
Adult Day Health Care, Case Management, Dental, Durable Medical Equipment, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Long Term Care, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

CALIFORNIA
Sutter Senior Care

Subpopulations Excluded from Otherwise Included Populations:

-Poverty Level Pregnant Woman
-Enrolled in Another Managed Care Program
-Special Needs Children

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Health Fairs, presentations, Senior Groups
-Uses eligibility data to identify members of these groups
-Uses mass mailings to potential enrollees.

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Sutter Senior Care

ADDITIONAL INFORMATION

If the potential participant meets the eligibility requirements for enrollment into the PACE program, which is 55 years and older,lives in the plans approved service area, and is certified for nursing facility level of care and elects to enroll in the PACE program, the participant will remain enrolled in the program unless he or she chooses to voluntarily disenroll from the plan or is involuntarily disenrolled by the plan with DHS approval.

This program provides a full continuum of medical, social and long term care services to nursing home eligibles age 55 and over who live in a specific geographic area.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Does Not Collect Quality Data

Use of Collected Data

-Not Applicable

Consumer Self-Report Data

None

Use of HEDIS

-Not Applicable

Standards/Accreditation

MCO/PIHP/PAHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Not Applicable

Sutter Senior Care

EQRO Organization
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
None

DELAWARE
Diamond State Health Plan

CONTACT INFORMATION

State Medicaid Contact:	Kay Holmes Delaware Social Services (302) 577-4903
State Website Address:	DSS.State.De.Us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
EDS, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 27, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
March 15, 2004

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B)
-1902(a)(13)(E)
-1902(a)(23) Freedom of Choice
-1902(a)(30)(A)
-1902(a)(34)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(ii)(vi)
-1903(m)(2)(A)(vi) Eligibility Expansion, Family Planning, IMD

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Other Delaware Medicaid Services, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Skilled Nursing Facility, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Other Specialists Approved on a Case-by-Case Basis

DELAWARE

Diamond State Health Plan

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver
- CHAMPUS

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Foster Care Children
- Aged and Related Populations
- Pregnant Women
- Expanded Population Adults Under 100% FPL

Lock-In Provision:
12 month lock-in

Enhanced Fee-For-Service - Fee-for-Service

Service Delivery

Included Services:
All Other Delaware Medicaid Services, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Skilled Nursing Facility, Vision, X-Ray

Allowable PCPs:
- Pediatricians
- General Practitioners
- Family Practitioners
- Internists
- Obstetricians/Gynecologists
- Nurse Practitioners
- Nurse Midwives
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- Pregnant Women
- Expanded Population Adults Under 100% FPL

Subpopulations Excluded from Otherwise Included Populations:
- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver
- CHAMPUS

Populations Mandatorily Enrolled:
None

Lock-In Provision:
12 month lock-in

DELAWARE
Diamond State Health Plan

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Enrollment Broker Contacts
-State developed advocacy group (Delaweans with Special Needs)
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Easter Seals
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

First State Health Plan

ADDITIONAL INFORMATION

This program offers very limited mental health and substance abuse benefits. Most of the mental health and substance abuse services are fee-for-service. Skilled nursing facility is covered for the first 30 days only. Private Duty Nursing is covered for 28 hours per week.This program includes emergency transportation only. Diamond State Partners is an enhanced fee-for-service plan and will not be reported under the enrollment report.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)

DELAWARE
Diamond State Health Plan

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments
Yes

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics
-Availability of language interpretation services
-Children's access to primary care practitioners

Clinical Topics
-Adolescent Immunization
-Asthma management
-Beta Blocker treatment after a heart attack
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-Childhood Immunization
-Diabetes management
-Otitis Media management
-Sickle cell anemia management

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation for Deeming
None

EQRO Organization
-QIO-like entity

Accreditation Required for Participation
None

EQRO Name
-Delmarva Foundation/Mercer

EQRO Mandatory Activities
-Validation of performance improvement projects

EQRO Optional Activities
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounter

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
- -Consumer Self-Report Data
- -Focused Studies
- -Ombudsman
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)

Use of Collected Data:
- -Contract Standard Compliance
- -Fraud and Abuse
- -Monitor Quality Improvement
- -Program Evaluation

Consumer Self-Report Data
- -CAHPS
  - Adult Medicaid AFDC Questionnaire
  - Child Medicaid AFDC Questionnaire

Performance Improvement Projects

Clinical Topics
- -Adolescent Immunization
- -Asthma management
- -Beta Blocker treatment after a heart attack
- -Breast cancer screening (Mammography)
- -Cervical cancer screening (Pap Test)
- -Childhood Immunization
- -Diabetes management
- -Otitis Media management
- -Sickle cell anemia management

Non-Clinical Topics
- -Availability of language interpretation services
- -Children's access to primary care practitioners

HAWAII
Hawaii QUEST

CONTACT INFORMATION

State Medicaid Contact:

Aileen Hiramatsu
Hawaii Department of Human Services, Med-QUEST Div
(808) 692-8050

State Website Address:

http://www.state.hi.us/dhs/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 16, 1993

Implementation Date:
August 01, 1994

Waiver Expiration Date:
March 31, 2005

Sections of Title XIX Waived:
-1902(a)(10)(A)(i)(I),(III),(IV),(VII)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(C)
-1902(a)(13)(A)(IV)
-1902(a)(17)(D)
-1902(a)(18)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(34)
-1902(a)(4)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi)
-MCO Definition 1903(m)(1)(A)
-MCO Definition 1903(m)(2)(A)(i)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Psychiatrists
-Other Specialists Approved on a Case-by-Case Basis

-Pediatricians

Enrollment

Populations Voluntarily Enrolled:
-Quest-Net Expansion Groups

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Special Needs Children
-Adults eligible to receive ESI

Lock-In Provision:
12 month lock-in

MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:
Crisis, Detoxification, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Opiate Treatment Programs, Outpatient Substance Use Disorders, Pharmacy, Residential Substance Use Disorders Treatment Programs

Allowable PCPs:
-Psychiatrists
-Psychologists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Special Needs Children
-Participate in HCBS Waiver
-All children are excluded

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency

HAWAII
Hawaii QUEST

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Aloha Care

Early Intervention Programs, Department of Health

HMSA-Medical

Child & Adolescent Mental Health Division, Department of Health

HMSA-Behavior Health for SMI

Kaiser Permanente

ADDITIONAL INFORMATION

This program provides medical and behavioral health services through competitive managed care delivery system. Aged, Blind/Disabled populations have the option to enroll in either a fee-for-service or a managed care programs for mental health services. Quest-Net Program was implemented on April 1, 1996 as a component of the 1115(a) Hawaii Quest primarily to serve as a safety net for persons who became ineligible for Hawaii Quest or Medicaid Fee-For-Service (FFS) because their assets or income exceeded the allowable retention limits. Individuals with medical coverage including Medicare or military coverage are not eligible for Quest-Net. Adults are provided with limited basic health coverage. Children who are not blind or disabled are provided the same Quest standard benefits: similarly, benefits provided under the Medicaid FFS program are provided for children who are blind and disabled. The person reserve standard for Quest-Net is $5000 for a single person and $7000 for a family of two. Add $500 for each additional family member. Income can not exceed 300% of the current Federal Poverty Level for Hawaii.

The dental services are still carved out of MCO contracts, but instead of delivering them through pre-paid dental plans, they are now paid FFS. The change was effective 10/1/01. Special needs children include children who satisfy the disability criteria under State law.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data

-Beneficiary Plan Selection
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-ADA - American Dental Association dental claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Adolescent well-care visit rates
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care

-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient discharges for MH/SUD conditions/1,000 beneficiaries
-Inpatient discharges/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Expenditures by medical category of service
-Net income

Health Plan/ Provider Characteristics

-Board Certification
-Languages Spoken (other than English)
-Provider turnover

-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics

-Beneficiary need for interpreter
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs

Performance Improvement Projects

Project Requirements

-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Pharmacy management
-Prescription drug abuse
-Well Child Care/EPSDT

Non-Clinical Topics

-Children's access to primary care practitioners

Standards/Accreditation

MCO/PIHP/PAHP Standards

-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Mountain-Pacific Quality Health Foundation

EQRO Organization

-Quality Improvement Organization (QIO)

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities

-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

KENTUCKY
Kentucky Health Care Partnership Program

CONTACT INFORMATION

State Medicaid Contact:	Russ Fendley Kentucky Department for Medicaid Services (502) 564-4321
State Website Address:	http://chs.state.ky.us

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 06, 1995

Implementation Date:
November 01, 1997

Waiver Expiration Date:
November 01, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(E)
-1902(a)(15)
-1902(a)(23) Freedom of Choice
-1902(a)(34)
-1902(aa)
-1902(c)(34) Retroactive eligibility

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Disenrollment
-Guaranteed Eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis

KENTUCKY
Kentucky Health Care Partnership Program

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Psychiatric Residential Treatment Facility PRTF
-Eligibility for Spend down
-Residents of Institutions for Mental Disease

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Most Medicaid Eligibles
-Dual Eligibles for Medicaid Services only

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Uses claims data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-KY Commission for Children with Special Health Care Needs
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Passport Health Plan

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Accreditation for Participation (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)

Use of Collected Data
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation

-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-Track Health Service provision

Consumer Self-Report Data

None

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Comparison to claims payment data
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

Yes

Performance Measures

KENTUCKY

Kentucky Health Care Partnership Program

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS's Quality Improvement System for managed Care (QISMC) Standards for Medicaid and Medicare
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation for Deeming
None

EQRO Organization
-Federally designated QIO- like Entity

Accreditation Required for Participation
-Plan required to obtain MCO/PIHP/PAHP accreditation by NCQA or other accrediting body

EQRO Name
-Health Care Review Corporation

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Review of high cost services and procedures
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as clams and encounters

MARYLAND
HealthChoice

CONTACT INFORMATION

State Medicaid Contact:	James Gardner Department of Health and Mental Hygiene (410) 767-1482
State Website Address:	http://www.dhmh.state.md.us/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Affiliated Computer Services State Health Care, LLC (ACS)

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 30, 1996

Implementation Date:
June 02, 1997

Waiver Expiration Date:
May 31, 2005

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(E)
-1902(a)(23) Freedom of Choice
-1902(a)(4)(A)
-1902(a)(47)
-1902(a)(5)
-1903(u)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Guaranteed Eligibility, IMD

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Diabetes Care, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Outpatient Substance Use Disorders, Pharmacy, Physician, Primary Mental Health, Skilled Nursing Facility, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners

MARYLAND

HealthChoice

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Institutionalized more than 30 days
-Eligibility for Less Than 6 Months
-If enrolled in Model Waiver for Fragile Children
-If determined Medically Needy Under a Spend Down
-A child in an out-of-State placement
-Inmates of public institutions
-Enrolled in Family Planning Waiver Program

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AMERIGROUP Maryland Inc.
JAI Medical System
Priority Partners MCO
Helix Family Choice
Maryland Physicians Care
United Health Care

ADDITIONAL INFORMATION

An eligible HealthChoice enrollee may be permitted to disenroll "for cause" from an MCO and enroll in another MCO outside of his/her annual right to change period if he/she is not hospitalized. Dental services provided for enrollees under 21 years old. The Department and not the MCOs are responsible for purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers. There are additional optional services that some MCOs provide for their enrollees such as dental services for adults. Medicaid recipients eligible for Maryland Medicaid Managed Care are guaranteed 6 months eligibility with exception of: Pregnant women in the Maryland Childrens Health Program, who are guaranteed eligibility for the duration of the pregnancy and 2 months postpartum, Children younger than 19 years old with income greater than 185 percent but less than 300 percent of federal poverty level enrolled in Maryland Childrens Health Program. Individuals who possess private health insurance or obtain health insurance through another source, and Inmates of public institutions.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire
    Child with Special Needs Questionnaire

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-National Standard Format (NSF)
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

Yes

-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality

-Patient satisfaction with care

Access/Availability of Care

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Drug Utilization
-Inpatient admissions/1,000 beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics

-Adolescent Well Care/EPSDT
-Childhood Immunization
-Diabetes management/care
-Lead toxicity
-Well Child Care/EPSDT

Non-Clinical Topics
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation for Deeming
-NCQA (National Committee for Quality Assurance)

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Delmarva Foundation for Medical Care, Inc.

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

MASSACHUSETTS

Mass Health

CONTACT INFORMATION

State Medicaid Contact:

Robin Callahan
Division of Medical Assistance
(617) 210-5317

State Website Address:

http://www.state.ma.us/dma/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 15, 1995

Implementation Date:
July 01, 1997

Waiver Expiration Date:
June 30, 2005

Sections of Title XIX Waived:

-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(C)
-1902(a)(13)(C)
-1902(a)(17)
-1902(a)(17)(D)
-1902(a)(23) Freedom of Choice
-1902(a)(30)(A)
-1902(a)(32)
-1902(a)(34)
-1902(a)(4)(A)

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-1903(m)(2)(A)(vi) Disenrollment
-Eligibility Expansion
-Inst. For Mental Disease
-Insurance Reimbursement

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility,

Allowable PCPs:

-Obstetricians/Gynecologists
-Nurse Practitioners
-Federally Qualified Health Centers (FQHCs)
-Other Specialists Approved on a Case-by-Case Basis
-Hospital Outpatient Departments
-Rural Health Clinics (RHCs)

Transportation, Vision, X-Ray

- -Nurse Midwives
- -General Practitioners
- -Family Practitioners
- -Pediatricians
- -Internists

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Over 65 years old
-Enrolled in Another Managed Care Program

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-TITLE XXI SCHIP
-Foster Care Children (BH carve-out)
-Blind/Disabled Children and Related Populations

Lock-In Provision:
No lock-in

MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:
Crisis, Detoxification, Diversionary Services, Emergency Services Programs, Inpatient Mental Health, Inpatient Substance Use Disorders Services, Mental Health Outpatient, Mental Health Residential, Opiate Treatment Programs, Outpatient Substance Use Disorders Services, Residential Substance Use Disorders Treatment Programs, Screening, Identification, and Brief Intervention

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Over 65

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Lock-In Provision:
No lock-in

MASSACHUSETTS
Mass Health

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Chiropractic (for under 21), Dental/Maxillofacial Only, Durable Medical Equipment, Early Intervention, Emergency Transportation, EPSDT, Family Planning, Hearing Aids, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Orthotics/Prosthetics, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Podiatry, Skilled Nursing Facilty Up To 100 Days, Therapy, Vision (medical), X-Ray

Allowable PCPs:

-Other Specialists Approved on a Case-by-Case Basis
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Over 65 years old

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Education Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Boston Medical Center HealthNet Plan
MA Behavioral Health Partnership
Network Health
Fallon Community Health Plan - MCO
Neighborhood Health Plan
Primary Care Clinician Plan

MASSACHUSETTS

Mass Health

ADDITIONAL INFORMATION

Mass Health has a behavioral carve-out for PCCM enrollees and for children in the care or custody of the Commonwealth. Regarding the MH/SUD PIHP included services, there is no long-term care in mental health residential or residential substance abuse treatment programs. The Outpatient Day programs are defined as full or part-time substance abuse or mental health services provided in an ambulatory setting. Some MCO Program services have age limitations.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire (modified)
  Adult Medicaid SSI Questionnaire (modified)
  Child Medicaid AFDC Questionnaire (modified)
  Child Medicaid SSI Questionnaire (modified)

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

Yes

- Plan Enrollment
- Diagnosis Codes
- Procedure Codes
- Revenue Codes

Performance Measures

Process Quality

- Adolescent immunization rate
- Breast Cancer screening rate
- Cervical cancer screening rate
- Check-ups after delivery
- Depression management/care
- Follow-up after hospitalization for mental illness
- Frequency of on-going prenatal care
- Immunizations for two year olds
- Initiation of prenatal care - timeliness of
- Well-child care visit rates in first 15 months of life
- Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality

- Patient satisfaction with care

Access/Availability of Care

- Adult's access to preventive/ambulatory health services
- Average wait time for an appointment with PCP
- Children's access to primary care practitioners

Use of Services/Utilization

- Average number of visits to MH/SUD providers per beneficiary
- Emergency room visits/1,000 beneficiary
- Inpatient admission for MH/SUD conditions/1,000 beneficiaries
- Inpatient admissions/1,000 beneficiary
- Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care

- Actual reserves held by plan
- Audited Financial Statement
- Days cash on hand
- Days in unpaid claims/claims outstanding
- Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
- Medical loss ratio
- Net income
- Net worth
- Outlier Spending Experience for Stoploss Ins
- State minimum reserve requirements
- Total revenue

Health Plan/ Provider Characteristics

- Provider turnover

Beneficiary Characteristics

- Other Agency Affliations
- Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

- MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
- All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics

- Adolescent Immunization
- Adolescent Well Care/EPSDT
- Childhood Immunization
- Coordination of care for persons with physical disabilities
- Coordination of primary and behavioral health care
- Pharmacy management
- Post-natal Care
- Pre-natal care
- Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PIHP/PAHP Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-QIO-like entity

Accreditation Required for Participation
None

EQRO Name
-MassPro

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data
-CAHPS
    Adult Medicaid AFDC Questionnaire (modified)
    Child Medicaid AFDC Questionnaire (modified)
    Child with Special Needs Questionnaire

Use of Collected Data:
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Depression medication management
-Diabetes management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

MASSACHUSETTS
Mass Health

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Children's access to primary care practitioners

Provider Characteristics
None

Use of Services/Utilization
-ALOS overall MH/SUD
-Average number of visits to MH/SUD providers per beneficiary
-Continuing Care rates / MH
-Discharge per 1000 MH/SUD
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Intensive Clinical Management MH/SUD/100,000
-Number of inpatient days MH/SUD
-Percentage of beneficiaries with at least one dental visit
-Pregnancy enhanced services MH/SUD / 100,000
-Re-admission rates of MH/SUD

Beneficiary Characteristics
-Disenrollment rate
-Percentage of beneficiaries who are auto-assigned to PCCM
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Coordination of primary and behavioral health care
-Deprssion management
-Diabetes management
-Emergency Room service utilization
-Hepatitis B screening and treatment
-Hospital Discharge Planning
-Inpatient maternity care and discharge planning
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Presciption drug abuse
-Sexually transmitted disease screening
-Well Child Care/EPSDT

Non-Clinical Topics
-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

MINNESOTA

MinnesotaCare Program For Families And Children

CONTACT INFORMATION

State Medicaid Contact:

Mary Kennedy
Minnesota Department of Human Services
(651) 282-9921

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility

Initial Waiver Approval Date:
April 27, 1995

Implementation Date:
July 01, 1995

Waiver Expiration Date:
June 30, 2005

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30) Utilization Review
-1902(a)(4) Contract-Specific Upper Payment
-1902(a)(4)(A) MEQC

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Eligibility Expansion, Eligibility Simplification, Medical Education Trust Fund

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All other MA Benefits Covered Except NF, ICF/MR and Home And Community Based Waiver, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable

Enrollment

MINNESOTA

MinnesotaCare Program For Families And Children

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Pregnant Women Up to 275 of FPG With Other Insurance
-Enrolled in Another Managed Care Program
-Individuals with household income above 150% of poverty with other health insurance
-Individuals with health insurance available through employment if subsidized at 50% or greater

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Pregnant Women And Children Whose Income Is At Or Below 275% FPG
-Parents and other relative caretakers whose household income is below 275% of poverty.

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Health Partners
Medica
UCARE

First Plan Blue
Itasca Medical Care
Metropolitan Health Plan

ADDITIONAL INFORMATION

Contractors are not required to identify PCPs. PCP provider types are designated by HMOs rather than State.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)

Use of Collected Data
-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

-Performance Measures (see below for details)

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
-Disenrollment Survey

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Ad hoc comparison to benchmarks and norms
-Ad hoc per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Limited analysis of encounter data submission to help determine data completeness

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Adolescent well-care visit rates
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management
-Diabetes management/care
-Immunizations for two year olds
-Influenza vaccination rate
-Lead screening rate
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality

-Patient satisfaction with care

-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care
-Average distance to PCP

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Medical loss ratio
-Net income
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics
-MCO/PIHP/PAHP/PCP-specific disenrollment rate

Use of Services/Utilization
-Well-child care visit rates in first 15 months of life

Health Plan/ Provider Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics
None

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care
-Childhood Immunization
-Well Child Care

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation for Deeming
None

EQRO Organization
-Private Accreditation Organization
-QIO-like entity
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-FMAS (QIO-like)
-MetaStar (QIO)
-Michigan PRO (QIO)
-MPQRO (QIO)
-NCQA (Accreditation)
-PRS (QIO)
-Stratis Health (QIO)

EQRO Mandatory Activities
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

MINNESOTA
Prepaid Medical Assistance Program

CONTACT INFORMATION

State Medicaid Contact:

Mary Kennedy
Minnesota Department of Human Services
(651) 297-7515

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
July 01, 1985

Implementation Date:
July 01, 1985

Waiver Expiration Date:
June 30, 2005

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(30) Utilization Review
-1902(a)(4) Contract-Specific Upper Payment
-1902(a)(4)(A) MEQC

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A) HMO Definition
-1903(m)(2)(A)(vi) Medical Education Trust Fund, El

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Other MA Benefits Covered Except Nursing Facility Per Diem, ICF/MR And Home And Community Based, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable

MINNESOTA
Prepaid Medical Assistance Program

Enrollment

Populations Voluntarily Enrolled:
- -Children with SED
- -Enrolled in another managed care program

Subpopulations Excluded from Otherwise Included Populations:
- -Non-documented Alien Recipients Who Only Receive Emergency MA Under Minn. Stat. 256B.06(4)
- -QMBs And SLMBs Who Are Not Otherwise Receiving MA
- -Recipients with terminal or communicable disease at time of enrollment
- -Those With Private Coverage With An HMO Not Participating In Medicaid
- -Refugee Assistance Program Recipients
- -Recipients Residing In State Institutions
- -Non-Institutionalized Recipients Who Are Eligible On A Spenddown Basis
- -Blind And Disabled Under Age 65

Populations Mandatorily Enrolled:
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Aged and Related Populations
- -TITLE XXI SCHIP
- -Foster care children

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- -Surveys medical needs of enrollee to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Aging Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Plus
Health Partners
Medica
PrimeWest Health System
UCARE
First Plan Blue
Itasca Medical Care
Metropolitan Health Plan
South Country Health Alliance

ADDITIONAL INFORMATION

Contractors are not required to identify PCPs. PCP provider types are designated by HMOs rather than State; county staff perform enrollment functions. PMAP provides one month rolling eligibility to provide coverage for enrollees who do not return a scheduled income or redetermination report on a timely basis.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -Focused Studies
- -MCO/PIHP/PAHP Standards (see below for details)
- -Monitoring of MCO/PIHP/PAHP Standards
- -Ombudsman
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -Provider Data

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Disenrollment Survey

Use of Collected Data

-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Ad hoc per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Limited analysis of encounter data submissions to help determine data completeness

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Cervical cancer screening rate
-Cholesterol screening and management
-Depression management
-Diabetes management/care
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
None

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
-Well-child care visit rates in first 15 months of life

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Medical loss ratio
-Net income
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
-MCO/PIHP/PAHP/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care
-Childhood Immunization
-Senior Influenza Immunization
-Smoking Cessation
-Well Child Care

Non-Clinical Topics
None

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-FMAS (QIO-like)
-MetaStar (QIO)
-Michigan PRO (QIO)
-NCQA (Accreditation)
-PRS (QIO)
-Stratis Health (QIO)

EQRO Organization
-Private Accreditation Organization
-QIO-like entity

EQRO Mandatory Activities
-Validation of performance measures

-Quality Improvement Organization (QIO)

EQRO Optional Activities

-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

MISSOURI
MC+ Managed Care/1115

CONTACT INFORMATION

State Medicaid Contact:

Susan Eggen
Department of Social Services, Division of Medical Services
(573) 751-5178

State Website Address:

http://www.state.mo.us

PROGRAM DATA

Program Service Area:
City
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Policy Studies, Inc.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
April 29, 1998

Implementation Date:
September 01, 1998

Waiver Expiration Date:
March 01, 2007

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(u) MEQC
-Eligibility Expansion
-Family Planning Eligibility Expansion
-Indigent/Clinic Expenditures

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation - Emergency only, Vision, X-Ray

Allowable PCPs:
-Internists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-PCP Teams
-Obstetricians/Gynecologists (Health Plans can choose to designate OB/GYNs for PCPs)
-PCP Clinics - which can include FQHCs/RHCs
-Pediatricians
-General Practitioners
-Family Practitioners

MISSOURI
MC+ Managed Care/1115

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Aid to the Blind and Blind Pension individuals
-Reside in Nursing Facility or ICF/MR
-Presumptive Eligibility for Children
-General Relief Program participants
-AIDS Waiver program participants
-Permanently and Totally Disabled Individuals
-Children enrolled in Developmental Disabilities Program
-Mentally retarded Developmental Disabled (MRDD) Waiver
-American Indian/Alaskan Native
-Presumptive Eligibility Program for Pregnant Women
-Medicare Dual Eligible

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP
-UNINSURED PARENTS - ME CODE 76

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Data Match with Other State Agencies
-Health Risk Assessments
-Helpline
-MCOs monitor Drug Usage
-MCOs use ER Encounters
-MCOs use Hospital Admissions
-MCOs use Hospital Encounters
-Reviews grievances and appeals to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Other State Agencies as necessary
-Public Health Agency
-Social Security Administration

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Blue Cross Blue Shield of Kansas City, Blue Advantage+ Plus
Family Health Partners
HealthCare USA
Missouri Care
Community Care Plus
FirstGuard
Mercy Health Plans

ADDITIONAL INFORMATION

Implementation Date: 09/01/1998 - Services began for MC+ For Kids. On 02/01/1999, services began for Uninsured Parents. Medicaid eligibles in the included populations who are receiving Supplemental Security Income (SSI) or who meet the SSI medical disability definition may choose not to enroll or voluntarily disenroll from MC+ at any time. Transportation - 1115 Adults and Children receive emergency transportation only. Dental services for 1115 Adults due to Trauma and Disease only. Vision services for 1115 Adults due to trauma or disease only, which includes one pair of glasses following cataract surgery. EPSDT: Uninsured Parents Age 19 and above do not receive EPDST services. Special Needs Children enrollment is mandatory but individuals may request to opt out. HealthCare USA plan participates in Eastern, Central, and Western Regions.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman (Western and Eastern Region only)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
    Children with Special Needs Questionnaire

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Monitor Quality Improvement
-Plan Reimbursement EPSDT
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

Collections: Submission Specifications

-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care - medication use
-Cervical cancer screening rate
-Check-ups after delivery
-Chemical Dependency Utilization
-C-Section Rates
-Dental services
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Mental Health Utilization
-Outcomes of Pregnancy
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Preventable Hospitalization under age 18
-Smoking during Pregnancy
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care

-Average distance to PCP

Use of Services/Utilization

-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care

-Missouri Department of Insurance monitors and tracks Health Plan stability/financial/cost of care

Health Plan/ Provider Characteristics

-Languages Spoken (other than English)

Beneficiary Characteristics

-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards

-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-Behavioral Health Concepts (BHC)

EQRO Mandatory Activities

-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities

-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

NEW YORK

Partnership Plan - Family Health Plus

CONTACT INFORMATION

State Medicaid Contact:

Linda LeClair
Office of Medicaid Management, New York State Department
(518) 474-8887

State Website Address:

http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus and Facilitated Enrollers

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
June 29, 2001

Implementation Date:
September 04, 2001

Waiver Expiration Date:
March 31, 2006

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(25)
-1902(a)(30)
-1902(a)(34)
-1902(a)(34) Retroactive Eligibility

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Eligibility Expansion, Guarantee
-1903(u) Special Program (Community Health Care Conversion Demonstration Program)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental (MCO option), Diabetic supplies and equipment, Durable Medical Equipment, Emergency ambulance transportation, EPSDT, Family Planning (MCO Option), Hearing, Home Health (40 visits), Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health (30 days per year), Inpatient Substance Use Disorders, Laboratory, Medically Managed Detox - Inpatient, Medically Supervised Withdrawal Services Inpatient/Outpatient, Outpatient Hospital, Outpatient Mental Health (60 days per year), Outpatient Substance Use Disorders, Physician, Prescription Drugs, Radiation Therapy, chemotherapy and hemodialysis, Smoking cessation products, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis

NEW YORK

Partnership Plan - Family Health Plus

Enrollment

Populations Voluntarily Enrolled:
-Adults 19-64 no children up to 100% FPL
-Adults 19-64 w/children up to 150% FPL

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Equivalent Insurance
-Medicare Dual Eligible

Populations Mandatorily Enrolled:
None

Lock-In Provision:
12 month lock-in

PPO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental (Plan option), Diabetic supplies and equipment, Durable Medical Equipment, Emergency ambulance transportation, EPSDT, Family Planning, Home Health (40 visits), Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health (30 days per year), Inpatient Substance Use Disorders, Laboratory, Medically Necessary Detox Inpatient, Medically Supervised withdrawal service Inp/Out, Outpatient Hospital, Outpatient Mental Health (60 days per year), Outpatient Substance Use Disorders, Physician, Prescription Drugs, Radiation therapy, chemotherapy and hemodialysis, Smoking cessation products, X-Ray

Allowable PCPs:
-Nurse Practitioners
-Pediatricians
-Internists
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Adults 19-64 no children up to 100% FPL
-Adults 19-64 w/children up to 150% of FPL

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Other Equivalent Insurance
-Medicare Dual Eligible

Populations Mandatorily Enrolled:
None

Lock-In Provision:
12 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

ABC Health Plan
Affinity Health Plan
Americhoice
Buffalo Community Health
Capital District Physicians Health Plan
CarePlus Health Plan
Catholic Services Health Plan/Fidelis
Community Choice Health Plan
Community Premier Plus
Excellus
GHI
GHI HMO Select
Health First
Health Now

NEW YORK

Partnership Plan - Family Health Plus

HIP Combined
Manhattan PHSP/Centercare
Neighborhood Health Providers
St. Barnabas/Partners in Health
United Healthcare of NY
Wellcare
LMC/Health Care Plus
MetroPlus Health Plan
NY Hospital Community PHSP
Syracuse PHSP/Total Care
United Healthcare of Upstate
Westchester PHSP

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of Collected Data

-Health Services Research
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

None

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Island Peer Review Organization

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

NEW YORK

Partnership Plan Medicaid Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:	Elizabeth McFarlane Office of Managed Care, New York State Department (518) 473-0122
State Website Address:	http://www.health.state.ny.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Maximus

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
July 15, 1997

Implementation Date:
October 01, 1997

Waiver Expiration Date:
March 31, 2006

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(C)
-1902(a)(23) Freedom of Choice
-1902(a)(25)
-1902(a)(30)
-1902(a)(34)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Eligibility Expansion, Guarantee
-1903(u) Special Program (Community Health Care Conversion Demonstration Program)

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental (MCO Option), Durable Medical Equipment, EPSDT, Family Planning (MCO Option), Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Skilled Nursing Facility, Transportation (Optional), Vision, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners

NEW YORK

Partnership Plan Medicaid Managed Care Program

Enrollment

Populations Voluntarily Enrolled:

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Enrolled in Another Managed Care Program
-Reside in Nursing Facility or ICF/MR
-Partcipation in LTC Demonstration Program
-Other Insurance
-Eligible less than 6 Months
-Spend downs
-Reside in State Operated Psychiatric facility
-Enrolled in the Restricted Recipient Program
-Reside in residential treatment facility for children and youth
-Infants weighing less than 1200 grams or infants who meet SSI criteria
-Special Needs Children (State defined)
-Admitted to hospice at the time of enrollment
-Foster children in direct care
-Eligible only for TB related services

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Adults and Related Populations
-NYS Home Relief Adults
-Section 1931 (AFDC/TANF) Children and Related Populations

Lock-In Provision:

12 month lock-in

NEW YORK
Partnership Plan Medicaid Managed Care Program

PCCM Provider - Partial Capitation

Service Delivery

Included Services:

Case Management, Dental, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray

Allowable PCPs:

-Nurse Practitioners
-Pediatricians
-Internists
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Residential Treatment Facility for children and youth
-Special Needs Children (State defined)
-Admitted to hospice at the time of enrollment
-Reside in Nursing Facility or ICF/MR
-Participation in a LTC Demonstration Program
-Other Insurance
-Eligible less than 6 Months
-Spend downs
-Reside in State Operated Psychiatric Facility
-Enrolled in the Restricted Recipient Program
-Foster care children in direct care
-Eligible only for TB related services
-Enrolled in Another Managed Care Program

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:

12 month lock-in

NEW YORK
Partnership Plan Medicaid Managed Care Program

PCCM Provider fee for service - Fee-for-Service

Service Delivery

Included Services:

Case Management, Durable Medical Equipment, EPSDT, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Skilled Nursing Facility, X-Ray

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in the Restricted Recipient Program
-Admitted to hospice at the time of enrollment
-Foster Care children in direct care
-Eligible only for TB Related Sevices
-Reside in residential treatment facility for children and yourth
-Infants weighing less than 1200grams or infants who meet SSI criteria
-Special Needs Children (State defined)
-Enrolled in Another Managed Care Program
-Reside in Nursing Facility or ICF/MR
-Participation in LTC Demonstration
-Other Insurance
-Eligible less than 6 months
-Spend downs
-Reside in State Operated Psychiatric Facility

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

NEW YORK

Partnership Plan Medicaid Managed Care Program

ABC Health Plan
Americhoice
Buffalo Community Health
CarePlus Health Plan
Community Choice Health Plan
Excellus
Health Choice
Health Now
Independent Health/Hudson Valley&WNY
Manhattan PHSP/Centercare
Neighborhood Health Providers
Physician Case Management Program
Primary Health
St. Barnabas/Partners in Health
Syracuse PHSP/Total Care
United Healthcare of NY
Vytra
Westchester PHSP

Affinity Health Plan
Broome County MC
Capital District Physicians Health Plan
Catholic Services Health Plan/Fidelis
Community Premier Plus
GHI HMO Select
Health First
HIP Combined
LMC/Health Care Plus
MetroPlus Health Plan
NY Hospital Community PHSP
Preferred Care
Southern Tier Pediatrics
Suffolk Health Plan
Twin Tier/ Southern Tier Priority
United Healthcare of Upstate
Wellcare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire

Use of Collected Data

-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Alcohol and Substance abuse use screening
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Depression management/care
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead Screening rate
-Smoking prevention and cessation
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care

-Average distance to PCP
-Ratio of PCPs to beneficiaries

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Use of Services/Utilization

-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary

-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics

-Information of beneficiary ethnicity/race
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs

Health Plan/ Provider Characteristics

-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics

-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Clinical Topics

-Inpatient maternity care and discharge planning
-Low birth-weight baby
-Newborn screening for heritable diseases
-Post-natal Care
-Pre-natal care

Standards/Accreditation

MCO/PIHP/PAHP Standards

-State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-Island Peer Review Organization

EQRO Mandatory Activities

-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

NEW YORK
Partnership Plan Medicaid Managed Care Program

Quality Oversight Activities:
- Consumer Self-Report Data
- Focused Studies
- On-Site Reviews
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data:
- Program Evaluation

Consumer Self-Report Data
- Provider developed survey

Performance Measures

Process Quality
- Diabetes management/care
- Immunizations for two year olds
- Lead screening rate

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

OKLAHOMA
SoonerCare

CONTACT INFORMATION

State Medicaid Contact:	Rebecca Pasternik-Ikard Oklahoma Health Care Authority (405) 522-7200
State Website Address:	http://www.ohca.state.ok.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
FirstHealth

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
October 12, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2003

Sections of Title XIX Waived:
-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(34)
-1902(a)(4)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(ii)
-1903(m)(2)(A)(vi)
-1903(m)(2)(A)(vi) Guranteed Eligibility

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Internists
-Obstetricians/Gynecologists
-Pediatricians
-General Practitioners
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

OKLAHOMA

SoonerCare

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- Children in permanent custody
- Medicare Dual Eligible
- Reside in Nursing Facility or ICF/MR
- Participate in HCBS Waiver
- Covered by an HMO

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- TITLE XXI SCHIP

Lock-In Provision:
12 month lock-in

PCCM Provider - Partial Capitation

Service Delivery

Included Services:
Case Management, EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

Allowable PCPs:
- Pediatricians
- General Practitioners
- Family Practitioners
- Internists
- Obstetricians/Gynecologists
- Federally Qualified Health Centers (FQHCs)
- Nurse Practitioners
- Nurse Midwives
- Physician Assistants
- Indian Health Service (IHS) Providers
- Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- Participate in HCBS Waiver
- Children In State Custody
- Medicare Dual Eligible
- Other Insurance
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- TITLE XXI SCHIP

Lock-In Provision:
No lock-in

American Indian Primary Care Case Management - Fee-for-Service

Service Delivery

Included Services:
Case Management

Allowable PCPs:
- -Indian Health Service (IHS) Providers
- -Tribal Provider
- -Urban Indian Clinic

Enrollment

Populations Voluntarily Enrolled:
- -TITLE XXI SCHIP
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
- -Medicare Dual Eligible
- -Reside in Nursing Facility or ICF/MR
- -Enrolled in Another Managed Care Program
- -Participate in HCBS Waiver
- -Children in State Custody
- -Enrolled in an HMO

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- -Asks advocacy groups to identify members of these groups
- -Surveys medical needs of enrollee to identify members of these groups
- -Uses eligibility data to identify members of these groups
- -Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Aging Agency
- -Education Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Social Services Agency
- -Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

American Indian PCCM
Prime Advantage
UNICARE
Heartland
SoonerCare PCCM

OKLAHOMA

SoonerCare

ADDITIONAL INFORMATION

Beneficiaries are auto assigned to either PCCM or MCO models depending on where they live.

No adult dental benefit from January 1,2003 through June 30, 2003.

American Indian Primary Care Case Management under this program allows the American Indian to participate in Indian Health Service (IHS) Providers, Tribal Provider, or Urban Indian Clinic in addition to the regular Sooner Care PCCM. The included populations are sub-categories of the American Indian populations. This portion of the Sooner Care program only includes American Indian population.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire
-Consumer/Beneficiary Focus Groups

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Reimbursement
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses ALL of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Required data quality improvement plans
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

OKLAHOMA
SoonerCare

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Dental services
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care

-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics

-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics

-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Childhood Immunization
-Coordination of care for persons with physical disabilities
-Depression management
-Emergency Room service utilization
-Newborn screening for heritable diseases
-Pre-natal care
-Presciption drug abuse
-Prevention of Influenza
-Well Child Care/EPSDT

Non-Clinical Topics

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PIHP/PAHP Standards

-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation for Deeming

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

-State recognizes accreditation but it is not required.

EQRO Name

-Oklahoma Foundation for Medical Quality

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Conduct performance improvement projects
-Conducts QISMC Reviews of MCOs/PIHPs/PAHPs and PCCM program
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:

None

OKLAHOMA
SoonerCare

Consumer Self-Report Data
None

Performance Measures

Process Quality
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
None

Access/Availability of Care
None

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
None

Non-Clinical Topics
None

OREGON

Oregon Health Plan

CONTACT INFORMATION

State Medicaid Contact:

Joan Kapowich
Office of Medical Assistance Programs
(503) 945-6500

State Website Address:

http://www.omap.hr.state.or.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
March 19, 1993

Implementation Date:
February 01, 1994

Waiver Expiration Date:
January 31, 2005

Sections of Title XIX Waived:

-1902(a(34)
-1902(a)(10)
-1902(a)(10)(A)
-1902(a)(10)(B) Comparability of Services
-1902(a)(10)(C)
-1902(a)(13)(A)
-1902(a)(17)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(43)(A)
-1905(a)(13)
-2103
-2103(e)

Sections of Title XIX Costs Not Otherwise Matchable Granted:

-1903(f)
-1903(m)(1)(A)
-1903(m)(2)(A)
-1903(m)(2)(A)(vi) Eligibility Expansion, Guarantee Eligibility, Disenrollment
-1905(a)(13) Chemical Dependency Treatment
-Employer Sponsored Insurance
-Inst. For Mental Disease

SERVICE DELIVERY

MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:
Crisis, IMD, Inpatient Mental Health, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Support, Outpatient Substance Use Disorders

Allowable PCPs:
-Does not apply

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Lock-In Provision:
6 month lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management

Allowable PCPs:
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Pediatricians
-General Practitioners
-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Pregnant Women and Optional Children
-Medicare Dual Eligible
-American Indian/Alaskan Native

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-Aged and Related Populations
-TITLE XXI SCHIP
-Pregnant Women and Optional Children
-Medicare Dual Eligible
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Lock-In Provision:
No lock-in

Dental PAHP - Full Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Does not apply

Enrollment

Populations Voluntarily Enrolled:
-Medicare Dual Eligible
-American Indian/Alaskan Native
-Foster Care Children
-Pregnant Women and Optional Children

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Populations Mandatorily Enrolled:
-Medicare Dual Eligible
-American Indian/Alaskan Native
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Pregnant Women and Optional Children

Lock-In Provision:
6 month lock-in

OREGON
Oregon Health Plan

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Rural Health Clinics (RHCs)
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-Pregnant Women and Optional Children
-Medicare Dual Eligible
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Enrolled in Another Managed Care Program
-QMB and MN Spenddown

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Pregnant Women and Optional Children
-Medicare Dual Eligible
-American Indian/Alaskan Native

Lock-In Provision:
6 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Asks advocacy groups to identify members of these groups
-Health Plans use multiple means to identify such members
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Education Agency
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

OREGON
Oregon Health Plan

Capitol Dental Care Inc.
Cascade Comprehensive Care
Clackamas County Mental Health
Doctors of the Oregon Coast South
FamilyCare (Mental Health)
Greater Oregon Behavioral Health, Inc.
Inter-Community Health Network
Lane Care MHO
Managed Dental Care of Oregon
Mid Valley Behavioral Care Network
Multicare Dental
Northwest Dental Services
Oregon Health Management Service
Providence Health Plan
Tuality Health Care
Willamette Dental
Care Oregon
Central Oregon Independent Health Services
Deschutes County CDO
Douglas County IPA
FamilyCare Health Plans
Hayden Family Dentistry
Jefferson Behavioral Health
Lane Individual Practice Association
Marion Polk Community Health Plan
Mid-Rogue Independent Practice Assoc.
Multnomah County Verity
Oregon Dental Service
PCCM
Tuality Health Alliance (Mental Health)
Washington County Health (Mental Health)

ADDITIONAL INFORMATION

1902(a)(1) Statewideness was waived under the uniformity section.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-External Quality Review
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

-CAHPS
Adult/Child Survey with selected Medicaid, Special Needs, and Oregon Specific Questions

Use of Collected Data

-claims, encounters, and medical records comparison to national standards
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Specifications for the submission of encounter data to the

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission

Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Diabetes management/care
-Immunizations for two year olds
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Preventive dental services
-Timeliness of prenatal care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care
-Adult access to ambulatory and preventive care
-Average wait time for an appointment with PCP
-Child Access to PCP's
-Percentage of eligibles enrolled in a FCHP or PCCM

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Claims outstanding
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio

Health Status/Outcomes Quality
-Patient satisfaction with care
-Patient self reporting health status

Use of Services/Utilization
-Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics
-Board Certification
-Credentials Review
-Languages Spoken (other than English)

-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics
-Beneficiary need for information in an alternate format
-Information of beneficiary ethnicity/race

Performance Improvement Projects

Project Requirements
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics
None

Clinical Topics
-Childhood Immunization
-Early childhood cavities prevention
-Smoking prevention and cessation

Standards/Accreditation

MCO/PIHP/PAHP Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-OMPRO

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of encounter data

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Ombudsman

Consumer Self-Report Data
-CAHPS
"Core" Adult/child Survey w/selected medicaid and special needs questions

Use of Collected Data:
-Health Services Research
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

RHODE ISLAND
Rite Care

CONTACT INFORMATION

State Medicaid Contact:

Tricia Leddy
Center for Child & Family Health
(401) 462-2127

State Website Address:

http://www.state.ri.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
November 01, 1993

Implementation Date:
August 01, 1994

Waiver Expiration Date:
July 31, 2005

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(A)(ii)(I)(II)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(E)
-1902(a)(14)
-1902(a)(17)(b)
-1902(a)(23) Freedom of Choice
-1902(a)(34)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(1)(A)
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Eligibility Expansion, Family Planning, IMD

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Interpreter, Laboratory, Nutrition, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Smoking Cessation, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Nurse Practitioners

-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:

-Foster Care Children

Subpopulations Excluded from Otherwise Included Populations:

-Participate in HCBS Waiver
-Medicare Dual Eligible
-American Indian/Alaskan Native
-Access to Cost Effective, Comprehensive, Employer-Sponsored Coverage

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Pregnant Women

Lock-In Provision:

No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coordinated Health Partners
United HealthCare of NE
Neighborhood Health Plan of RI

ADDITIONAL INFORMATION

Effective May 1, 1997, eligibility was expanded to include children in families with income up to 250% federal poverty level to age 18. Program has a one month open enrollment period every 12 months. As of 7/1/99, 18 year olds are eligible regardless of school status. Also, as of 11/1/98, parents of eligible children may be found eligible at family incomes up to 185% FPL under the States implementation of Section 1931. As of January, 2001, these parents and pregnant/pp women between 185-250% FPL are included under a waiver to RIs SCHIP program. Foster children have been included in RIte Care since November, 2000. From November, 2001, otherwise ineligible alien pregnant women receive services under SCHIP on behalf of their unborn children. The Rhode Island SCHIP program operates as a part of Rite Care.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Grievances and Appeals
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-Consumer Advisory Committee
-Consumer/Beneficiary Focus Groups
-State-developed Survey

Use of Collected Data

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or

all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison of State data with plan-specifc data
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Monitoring submision processes from providers to health plans to assure complete and timely submissions
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Cervical cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

RHODE ISLAND
Rite Care

Access/Availability of Care
-Average wait time for an appointment with PCP
-Complaint Resolution Statistics
-Patient/Member Satisfaction with Access to Care
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information on primary languages spoken by beneficiaries
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation for Deeming
None

EQRO Organization
-Undetermined at this time

Accreditation Required for Participation
None

EQRO Name
-Undetermined at this time

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters

TENNESSEE
TennCare

CONTACT INFORMATION

State Medicaid Contact:

Manny Martins
TennCare
(615) 741-0213

State Website Address:

http://www.state.tn.us/tenncare

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
November 18, 1993

Implementation Date:
January 01, 1994

Waiver Expiration Date:
June 30, 2007

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(A)
-1902(a)(13)(C)
-1902(a)(23) Freedom of Choice
-1902(a)(30)
-1902(a)(34)
-1902(a)(54)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(1)(A)
-1903(m)(2)(A)(i)
-1903(m)(2)(A)(vi) Eligibility Expansion, IMD

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Title XIX Medicaid services are covered except Long Term Care and Medicare crossovers., Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists
-Rural Health Centers (RHCs)
-Public Health Departments and Clinics
-Internists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Medically Needy
-Uninsured
-Uninsurable

Subpopulations Excluded from Otherwise Included Populations:
-Individuals not qualifying under traditional Medicaid criteria and have access to private insurance

Lock-In Provision:
12 month lock-in

MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:
Crisis, Detoxification, Inpatient Mental Health, Inpatient Substance Use Disorders Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders Services, Residential Substance Use Disorders Treatment Programs

Allowable PCPs:
-Public Health Departments and Clinics
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Pediatricians
-General Practitioners
-Family Practitioners

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP
-Medically needy
-Uninsured
-Uninsurables

Subpopulations Excluded from Otherwise Included Populations:
-Individuals not qualifying under traditional Medicaid criteria and have access to private insurance

Lock-In Provision:
12 month lock-in

TENNESSEE
TennCare

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Mental Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Better Health Plan
Memphis Managed Care Corp. (TLC)
Preferred Health Partnership/PHP
Tennessee Behavioral Health, Inc.
VUMC Care (VHP Community Care)
John Deere/Heritage National Health Plan
Omnicare Health Plan
Premier Behavioral Systems of TN
Volunteer State Health Plan (Bluecare)
Xantus Health Care

ADDITIONAL INFORMATION

All medically necessary services are provided through the managed care organizations. All mental health and substance use disorder services are provided through behavioral health organizations. The State has carved out Pharmacy services for those individuals who are both TennCare enrollees and eligible for Medicare.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

None

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

data submission

Collection: Standardized Forms

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Follow-up after hospitalization for mental illness
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Pregnancy Prevention
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care

-Average distance to PCP
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Use of Services/Utilization

-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

TENNESSEE

TennCare

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Annual Financial Statements
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Quarterly Financial Statements
-State minimum reserve requirements
-Total revenue
-Weekly Claims Inventory Reports

Beneficiary Characteristics

-Information of beneficiary ethnicity/race
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs

Health Plan/ Provider Characteristics

-Provider turnover

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics

-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Cholesterol screening and management
-Coordination of primary and behavioral health care
-Coronary artery disease prevention
-Diabetes management/care
-Emergency Room service utilization
-Hospital Discharge Planning
-Lead toxicity
-Low birth-weight baby
-Newborn screening for heritable diseases
-Pharmacy management
-Post-natal Care
-Pre-natal care
-Presciption drug abuse
-Sickle cell anemia management
-Well Child Care/EPSDT

Non-Clinical Topics

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PIHP/PAHP Standards

-NCQA(National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-First Health

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct performance improvement projects
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

UTAH

Primary Care Network (PCN)

CONTACT INFORMATION

State Medicaid Contact:

Gayleen Henderson
Utah Department of Health
(801) 538-6135

State Website Address:

http://www.state.ut.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
February 08, 2002

Implementation Date:
July 01, 2002

Waiver Expiration Date:
July 31, 2007

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice
-1902(a)(43)(A) EPDST

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1916(a) Cost Sharing
-Eligibility Expansion

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Dental, Diabetes Products, Emergency Room Services, Emergency Transportation, Family Planning, Immunization, Laboratory, Pharmacy, Physician, Vision, X-Ray

Allowable PCPs:
-Family Practitioners
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Pediatricians
-Federally Qualified Health Centers (FQHCs)
-Indian Health Service (IHS) Providers

Enrollment

Primary Care Network (PCN)

Populations Voluntarily Enrolled:
-Adults age 19 and above at 150% of the FPL

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program
-Special Needs Children (BBA defined)
-Other Insurance

Populations Mandatorily Enrolled:
None

Lock-In Provision:
12 month lock-in

Mental Health (MH) PIHP - Full Capitation

Service Delivery

Included Services:
Crisis, IMD Services, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Transportation

Contractor Types:
-CMHC Operated Entity (Public)
-County Operated Entity (Public)
-CMHC - some private; some governmental

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Resident of the Utah State Hospital (IMD)
-Resident of the State Develpmental Center (DD/MR facility)
-Title XXI CHIP

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Section 1925 (Traditional Medical Assistance) Adults
-Medically Needy (not aged, blind, or disabled) Adults

Lock-In Provision:
1 month lock-in

UTAH
Primary Care Network (PCN)

Medical-only PIHP (non-risk, comprehensive) - Fee-for-Service

Service Delivery

Included Services:
Case Management, Diabetes self-management, Durable Medical Equipment, Enhanced Services to Pregnant Women, EPSDT, ESRD, Family Planning, Hearing, HIV Prevention, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient medical detoxification, Laboratory, Medical Supples, Occupational Therapy, Outpatient Hospital, Personal Care, Physical Therapy, Physician, Podiatry, Preventive, Private Duty Nursing, Skilled Nursing Facility (less than 30 days), Speech Therapy, Vision, Well-adult care, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
-Reside in the State Hospital (IMD) or in the State Developmental Center (DD/MR)
-During Retroactive Eligibility Period
-If approved as exempt from mandatory enrollment
-Reside in Nursing Facility or ICF/MR
-Eligibility Less Than 3 Months

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Section 1925 (Traditional Medical Assistance) Adults
-Medically Needy (not aged, blind, or disabled) Adults

Lock-In Provision:
1 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Bear River Mental Health
Davis Mental Health
Healthy U
Molina Healthcare of Utah (AFC Plus)
Northeastern Counseling Center
Utah Primary Care Network (PCN)
Wasatch Mental Health
Central Utah Mental
Four Corners Mental Health
IHC Health Plans Inc.
Molina Healthcare of Utah (AFC UTAH)
Southwest Mental Health
Valley Mental Health
Weber Mental Health

ADDITIONAL INFORMATION

PCN program is a statewide section 1115 demonstration to expand Medicaid coverage. PCN also offers the full Medicaid state plan package to certain high-risk pregnant women with assets in excess of state plan levels, and a primary/preventive package to certain adults age 19 and above, with incomes under 150% FPL, who are not otherwise Medicaid-eligible. The PIHP contracts covering physical health care are non-risk. Medicaid reimburses each of these contractors for services. The PIHP contracts covering mental health care are risk-based.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

UTAH
Primary Care Network (PCN)

State Quality Assessment and Improvement Activities:
- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -Focused Studies
- -MCO/PIHP/PAHP Standards (see below for details)
- -Monitoring of MCO/PIHP/PAHP Standards
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)

Use of Collected Data
- -Contract Standard Compliance
- -Monitor Quality Improvement
- -Plan Reimbursement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Track Health Service provision

Consumer Self-Report Data
- -State-developed Survey

Use of HEDIS
- -The State DOES NOT use any of the HEDIS measures
- -The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future

Encounter Data

Collection: Requirements
- -Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
- -Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
- -Specifications for the submission of encounter data to the Medicaid agency
- -Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
- -Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
- -Deadlines for regular/ongoing encounter data submission(s)
- -Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
- -Guidelines for initial encounter data submission
- -Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
- -ANSI ASC X12 837 - transaction set format for transmitting health care claims data
- -NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
- -UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

Validation: Methods
- -Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
- -Date of Service
- -Medicaid Eligibility
- -Plan Enrollment
- -Diagnosis Codes
- -Procedure Codes
- -Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
- -Continuity of Care
- -Symptom reduction

Health Status/Outcomes Quality
- -Patient satisfaction with care
- -Racidivism
- -Symptom reduction

UTAH
Primary Care Network (PCN)

Access/Availability of Care
-Average time for intake
-Use of Services/Utilization

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net worth
-State minimum reserve requirements

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on age and gender
-Information on primary languages spoken by beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics
-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-In-house

Accreditation Required for Participation
None

EQRO Name
-State of Utah

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-On-Site Reviews

Use of Collected Data:
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Track Health Service provision

Consumer Self-Report Data

None

VERMONT

Vermont Health Access

CONTACT INFORMATION

State Medicaid Contact:

Russell Frank
Vermont Health Access Plan
(802) 241-1231

State Website Address:

http://www.dsw.state.vt.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
No

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
July 28, 1995

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2003

Sections of Title XIX Waived:
-1902(a)(10)
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)(A)
-1902(a)(13)(C)
-1902(a)(13)(E)
-1902(a)(14)
-1902(a)(23) Freedom of Choice
-1902(a)(30)(A)
-1902(a)(34)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1903(m)(2)(A)(vi) Eligibility Expansion, Guaranteed Eligibility, IMD

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis
-Indian Health Service (IHS) Providers
-Obstetricians/Gynecologists
-General Practitioners
-Family Practitioners
-Internists

VERMONT
Vermont Health Access

Enrollment

Populations Voluntarily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:
- Enrolled in Another Managed Care Program
- Participate in HCBS Waiver
- Spenddown
- Children who participate in Vermont High Tech Home Care Program
- Medicare Dual Eligible
- Other Insurance
- Reside in Nursing Facility or ICF/MR

Populations Mandatorily Enrolled:
- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- Foster Care Children
- TITLE XXI SCHIP

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- Education Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PC PLUS

ADDITIONAL INFORMATION

Allowable PCP Specialists: OB/GYNs or GYNs may be approved to be PCPs on a case-by-case basis.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
- Consumer Self-Report Data
- Enrollee Hotlines
- Focused Studies
- Ombudsman
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data:
- Monitor Quality Improvement
- Regulatory Compliance/Federal Reporting

VERMONT

Vermont Health Access

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire

Performance Measures

Process Quality

-Asthma care - medication use
-Depression medication management
-Diabetes management/care

Access/Availability of Care

None

Provider Characteristics

None

Health Status/Outcomes Quality

None

Use of Services/Utilization

None

Beneficiary Characteristics

None

Performance Improvement Projects

Clinical Topics

-Coordination of primary and behavioral health care
-Depression management
-Pharmacy management

Non-Clinical Topics

None

WISCONSIN
BadgerCare [SCHIP]

CONTACT INFORMATION

State Medicaid Contact:

Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:

http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
April 01, 1999

Implementation Date:
July 01, 1999

Waiver Expiration Date:
March 31, 2004

Sections of Title XIX Waived:
-1902(a)(10)(B) Comparability of Services
-1902(a)(23) Freedom of Choice

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1916(a) Cost Sharing
-Eligibility Expansion

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Pediatricians
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-TITLE XXI SCHIP
-Custodial Parents (And Their Spouses) Of Children Eligible

Through Title XXI SCHIP (BadgerCare)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Migrant workers
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Residents residing in FFS counties

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-County Departments for Mental Health, Substance Abuse, Social Services, Etc.
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Atrium Health Plan -- BadgerCare SCHIP
Group Health Cooperative Of Eau Claire -- BadgerCare SCHIP
Health Tradition Health Plan -- BadgerCare SCHIP
MercyCare Insurance Company -- BadgerCare SCHIP
Security Health Plan -- BadgerCare SCHIP
UnitedHealthcare of WI -- BadgerCare SCHIP
Valley Health Plan -- BadgerCare SCHIP
Dean Health Plan -- BadgerCare SCHIP
Group Health Cooperative Of South Central WI -- BadgerCare SCHIP
Managed Health Services -- BadgerCare SCHIP
Network Health Plan -- BadgerCare SCHIP
Touchpoint Health Plan -- BadgerCare SCHIP
Unity Health Insurance -- BadgerCare SCHIP

ADDITIONAL INFORMATION

BadgerCare is the Wisconsin Title XXI SCHIP managed care program. It has the same benefit package and contracts with the same HMO plans as the Wisconsin Medicaid HMO Program. BadgerCare enrolls children and parents with specific requirements for income level, lack of other insurance coverage, and other factors. On 07/01/1999, BadgerCare began operating under an 1115 demonstration waiver initially approved on 04/01/1999 and amended on 01/18/2001. BadgerCare also received waiver authority on 04/01/1999, and as later amended on 01/18/2001, regarding Title XIX and Title XXI requirements as follows: * T-19=Retroactive Eligibility, waiving Section 1902(a)(34); * T-19=Costs Not Otherwise Matchable for three Demonstration Populations, under Section 1115(a)(2) authority; * T-19=Freedom of Choice, waiving Section 1902(a)(23); * T-19=Comparability of Services, waiving Section 1902(a)(10)(B); * T-19=Eligibility, waiving Sections 1902(a)(17), 1902(a)(34), and 1931(b); * T-19=Cost Sharing Limitations, waiving Section 1916(a); * T-21=Costs Not Otherwise Matchable for Demonstration Population #3, under Section 1115(a)(2) authority; * T-21=General Requirements, Eligibility and Outreach, waiving Section 2102; * T-21=Restrictions on Coverage and Eligibility to Targeted Low Income Children, waiving Sections 2103 and 2110; * T-21=Federal Matching Payment and Family Coverage Limits, waiving Section 2105; * T-21=Annual Reporting Requirements, waiving Section 2108. Other special circumstances: enrollment varies by county; summary and detailed claims data required; HMOs required to coordinate with WIC, county non-MA programs, and other local agencies and programs.□

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-State-developed Survey

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Admission Source
-Admission Type

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

Yes

-Days Supply
-Modifier Codes
-Patient Status Code
-Place of Service Codes
-Quantity

Performance Measures

Process Quality

-Breast Cancer screening rate
-Cervical cancer screening rate
-Children with at least one comprehensive EPSDT well child visit in the look-back period at age 3-5 years,6-14 years, and 15-20 years
-Children with at least one non-EPSDT well-child visit in the look-back period at ages birth-1 year, 1-2 years, 3-5 years, 6-14 years and 15-20 years
-Comprehensive EPSDT well-child visits for children age birth to two years for those receiving 5,6,and 7, or more visits
-Dental services
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age

Health Status/Outcomes Quality

-Breast malignancies detected
-Cervix/uterus malignancies detected
-HPV infections detected
-Patient satisfaction with care

Access/Availability of Care

-Average distance to PCP
-Provider network data on geographic distribution
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care

None

Health Plan/ Provider Characteristics

-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards

-State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

-AAAHC (Accreditation Association for Ambulatory Health Care)
-All accrediting body standards are subject to review/acceptance for deeming
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Organization

-Quality Improvement Organization (QIO)

EQRO Name

-MetaStar

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities

-Calculation of performance measures
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

WISCONSIN
Wisconsin Partnership Program

CONTACT INFORMATION

State Medicaid Contact:

Steven Landkamer
DHFS/DDES/CDSD
(608) 261-7811

State Website Address:

http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1115 - Demonstration Waiver Program

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
January 01, 1996

Implementation Date:
January 01, 1996

Waiver Expiration Date:
December 31, 2003

Sections of Title XIX Waived:
-1902(a)(1) Statewideness
-1902(a)(10)(B) Comparability of Services
-1902(a)(13)
-1902(a)(20)
-1902(a)(23) Freedom of Choice
-1902(a)(7)

Sections of Title XIX Costs Not Otherwise Matchable Granted:
-1916(a) Cost Sharing
-HCBS

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Other WI Medicaid Services, Case Management, Durable Medical Equipment, Hearing, Home Health, Hospice, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Internists
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

WISCONSIN

Wisconsin Partnership Program

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Populations Mandatorily Enrolled:
None

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Aging Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community Care Organization - Partnership
Community Living Alliance -- Partnership
Community Health Partnership -- Partnership
Elder Care Of Dane County - Partnership

ADDITIONAL INFORMATION

The Wisconsin Partnership Program began operating under a dual Medicaid--Medicare waiver in January 1999. This demonstration project provides comprehensive Medicaid and Medicare services for older adults (ages 65+) and people with physical disabilities (ages 18-64). The Partnership Program integrates health and long-term support services and includes home- and community-based care, physician services, and all other medical care. Services are delivered in the participants home or a setting of his or her choice. Team-based care management is a key component of the program.☐ Enrollees must meet nursing home level-of-care or have substaintial illness or disability.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data
-Contract Standard Compliance
-Monitor Quality Improvement

Consumer Self-Report Data
-CAHPS
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
-State-developed Survey

Use of HEDIS
-The State DOES NOT use any of the HEDIS measures
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid

WISCONSIN
Wisconsin Partnership Program

Encounter Data

Collection: Requirements
-CMS Requirements

Collection: Standardized Forms
None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications
None

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Access/Availability of Care
None

Health Plan Stability/ Financial/Cost of Care
None

Beneficiary Characteristics
None

Health Status/Outcomes Quality
-Patient satisfaction with care

Use of Services/Utilization
-Number of hospital admissions per member per year
-Number of hospital days per member per year
-Percentage of beneficiaries with at least one dental visit
-Percentage of people living at home, CBRF/group home, nursing home

Health Plan/ Provider Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-MetaStar

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures

Section:
1932(a) State Plan Amendments

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ALABAMA
Maternity Care Program

CONTACT INFORMATION

State Medicaid Contact:

Gloria Luster
Alabama Medicaid Agency
(334) 353-5539

State Website Address:

http://www.medicaid.state.al.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
June 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Home Visits, Inpatient Hospital, Outpatient Hospital, Physician

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Nurse Midwives
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Poverty Level Pregnant Women
-Section 1931 (AFDC/TANF) Children and Related Populations

ALABAMA
Maternity Care Program

Subpopulations Excluded from Otherwise Included Populations:

- -Medicare Dual Eligible
- -American Indian/Alaskan Native
- -Other Insurance
- -Foster Children
- -Special Needs Children (State defined)
- -Special Needs Children (BBA defined)

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Developmental Disabilities Agency
- -Mental Health Agency
- -Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Maternity Care Program

ADDITIONAL INFORMATION

This program has been converted from a 1915(b) to a 1932.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Provider Data

Use of Collected Data:

- -Beneficiary Provider Selection
- -Contract Standard Compliance
- -Program Evaluation
- -Track Health Service provision

Consumer Self-Report Data
None

Performance Improvement Projects

Clinical Topics
None

Non-Clinical Topics
-Access to early prenatal care

GEORGIA

Georgia Better Health Care

CONTACT INFORMATION

State Medicaid Contact:	Kathrine Driggers Division of Managed Care and Quality (404) 657-7793
State Website Address:	http://www.dch.state.ga.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 2002

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Home Health, Immunization, In-home Nursing, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Poverty Level Pregnant Woman
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)
-SOBRA Eligible Pregnant Women
-Medicare Dual Eligible

Lock-In Provision:

6 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Georgia Better Health Care

ADDITIONAL INFORMATION

Program was converted from a 1915(b) to 1932(a) on December 1, 2002.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Enrollee Hotlines
-On-Site Reviews
-Performance Measures (see below for details)

Use of Collected Data:

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data

-State-developed Survey

Performance Measures

GEORGIA

Georgia Better Health Care

Process Quality

-Adolescent immunization rate
-Adolescent well-care visits rates

Access/Availability of Care

-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Provider Characteristics

-Board Certification
-Languages spoken (other than English)

Health Status/Outcomes Quality

-Patient satisfaction with care

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Beneficiary Characteristics

-Percentage of beneficiaries who are auto-assigned to PCCM

IOWA

Iowa Medicaid Managed Health Care

CONTACT INFORMATION

State Medicaid Contact:

Dennis Janssen
Department of Human Services
(515) 281-8747

State Website Address:

http://www.dhs.state.ia.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
ACS/Consultec

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 1986

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment (MCO Option), EPSDT, Family Planning, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Pediatricians
-Nurse Practitioners
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)

Lock-In Provision:

6 month lock-in

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:

Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, X-Ray

Allowable PCPs:

-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Pediatricians
-Nurse Practitioners
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)
-Medicare Dual Eligible

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:

6 month lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Coventry Health Care
John Deere Health Plan, Inc.
Iowa Health Solutions
Medipass

ADDITIONAL INFORMATION

Effective April 1, 2001 program was converted from a 1915(b) to a 1932(a).

Coventry Health Care includes the optional services of Chiropractic and Durable Medical Equipment in addition to the basic contract services. Iowa Health Solutions has included the optional service of Durable Medical Equipment in addition to the basic contract services.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

IOWA

Iowa Medicaid Managed Health Care

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

None

Use of Collected Data

-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments

Yes

Performance Measures

IOWA

Iowa Medicaid Managed Health Care

Process Quality

-Adolescent immunization rate
-Asthma care - medication use
-Cervical cancer screening rate
-Follow-up after hospitalization for mental illness
-Immunizations for two year olds
-Influenza vaccines for high risk enrollees
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care

-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics

None

Health Status/Outcomes Quality

-Patient satisfaction with care

Use of Services/Utilization

-Drug Utilization
-Inpatient admissions/1,000 beneficiary

Health Plan/ Provider Characteristics

-Board Certification
-Provider turnover

Performance Improvement Projects

Project Requirements

-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics

-Availability of language interpretation services
-Children's access to primary care practitioners

Clinical Topics

None

Standards/Accreditation

MCO/PIHP/PAHP Standards

-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-NAIC (National Association of Insurance Commissioners) Standards
-State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name

-Iowa Foundation for Medical Care

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

-Validation of performance measures

EQRO Optional Activities

-Administration or validation of consumer or provider surveys

-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Enrollee Hotlines

-Focused Studies

-Performance Improvements Projects (see below for details)

-Performance Measures (see below for details)

Consumer Self-Report Data

None

Use of Collected Data:

-Beneficiary Provider Selection

-Contract Standard Compliance

-Program Evaluation

Performance Measures

Process Quality

None

Access/Availability of Care

-Average distance to primary care case manager

-Average wait time for an appointment with primary care case manager

-Ratio of primary care case managers to beneficiaries

Provider Characteristics

-Board Certification

-Provider turnover

Health Status/Outcomes Quality

-Patient satisfaction with care

Use of Services/Utilization

-Drug Utilization

-Inpatient admissions/1,000 beneficiary

-Number of primary care case manager visits per beneficiary

-Number of specialist visits per beneficiary

Beneficiary Characteristics

-Disenrollment rate

-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics

-Adolescent Immunization

-Adolescent Well Care/EPSDT

-Asthma management

-Childhood Immunization

-Well Child Care/EPSDT

Non-Clinical Topics

-Adults access to preventive/ambulatory health services

-Children's access to primary care practitioners

KANSAS
HealthConnect Kansas

CONTACT INFORMATION

State Medicaid Contact:

Janelle Garrison
Health Care Policy/Medical Policy
(785) 368-6293

State Website Address:

http://www.srskansas.org/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS, Inc

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1984

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Obstetrical, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Personal Care, Pharmacy, Physician, Therapies, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-Osteopaths
-Local Health Departments (LHDs)
-Other Specialists Approved on a Case-by-Case Basis
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Indian Health Service (IHS) Providers
-Nurse Midwives
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)

Enrollment

KANSAS

HealthConnect Kansas

Populations Voluntarily Enrolled:
-Special Needs Children (BBA-defined)
-Native American Adults
-American Indian/Alaskan Native Children

Subpopulations Excluded from Otherwise Included Populations:
-Medically Needy-eligible
-Foster Care Children
-Receive Adoption Support
-Spenddown Eligible
-Participate in HCBS Waiver
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Reside in Juvenile Justice Facility or other State Institution
-Reside in State Institution

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Pregnant Women

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Reviews complaints and grievances to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses information from Title V agency to identify members
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

HealthConnect Kansas

ADDITIONAL INFORMATION

Beneficiaries choose between a MCO and PCCM.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data
-CAHPS

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

KANSAS
HealthConnect Kansas

Adult Medicaid AFDC Questionnaire
Child Medicaid AFDC Questionnaire
Child with Special Needs Questionnaire

Performance Measures

Process Quality
-Adolescent immunization rate
-Cervical cancer screening rate
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Provider Characteristics
-Board Certification
-Languages spoken (other than English)
-Provider turnover

Health Status/Outcomes Quality
-Patient satisfaction with care

Use of Services/Utilization
-Drug Utilization

Beneficiary Characteristics
-Beneficiary need for interpreter
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM

KANSAS

HealthWave 19

CONTACT INFORMATION

State Medicaid Contact:

Debra Bachmann
Health Care Policy/Medical Policy
(785) 296-3667

State Website Address:

http://www.srskansas.org/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS, Inc

For All Areas Phased-In:
No

Guaranteed Eligibility:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Newborn, Nutrition, Occupational Therapy, Outpatient Hospital, Pharmacy, Physical Therapy, Physician, Podiatry, Prenatal Health Promotion, Speech Therapy, Transfusions, Transplants, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Nurse Midwives
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Special Needs Children (BBA-defined)
-Native American Adults

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

- -Enrolled in Another Managed Care Program
- -Participate in HCBS Waiver
- -Reside in State Hospitals
- -Medicare Dual Eligible
- -Reside in Nursing Facility or ICF/MR

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- -Reviews complaints and grievances to identify members of these groups
- -Uses eligibility data to identify members of these groups
- -Uses information from the Title V agency to identify members

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Education Agency
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

FirstGuard Health Plan Kansas, Inc.

ADDITIONAL INFORMATION

Beneficiaries choose between an MCO and PCCM.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -Focused Studies
- -MCO/PIHP/PAHP Standards (see below for details)
- -Monitoring of MCO/PIHP/PAHP Standards
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -Provider Data

Consumer Self-Report Data

- -CAHPS
    - Adult Medicaid AFDC Questionnaire
    - Child Medicaid AFDC Questionnaire
    - Child with Special Needs Questionnaire

Use of Collected Data

- -Contract Standard Compliance
- -Fraud and Abuse
- -Monitor Quality Improvement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting

Use of HEDIS

- -The State uses SOME of the HEDIS measures listed for Medicaid
- -The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
- -State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

KANSAS
HealthWave 19

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Procedure Codes
-Revenue Codes

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Diabetes medication management
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Drug Utilization

Health Plan Stability/ Financial/Cost of Care
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs

Performance Improvement Projects

Project Requirements
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Kansas Foundation for Medical Care

EQRO Mandatory Activities
-Validation of performance improvement projects

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters
-Validation of encounter data

KENTUCKY

Kentucky Patient Access and Care (KENPAC) Program

CONTACT INFORMATION

State Medicaid Contact:

Duane Dringerburg
KY Department for Medicaid Services
(502) 564-5969

State Website Address:

http://chs.state.ky.us/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 2000

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

KENTUCKY

Kentucky Patient Access and Care (KENPAC) Program

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Special Needs Children
-Spenddown
-American Indian/Alaskan Native
-Special Needs Children (BBA defined)

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Commission for Children with Special Health Care Needs
-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Kentucky Patient Access and Care (KenPAC)

ADDITIONAL INFORMATION

The KenPAC Program was implemented under a state plan ammendment in all counties in Kentucky except region 3 in April of 2000. For the following Included services- EPDST, Mental Health, and Maternaty Care including prenatal care delivery and post partum beneficiary may go to any participating provider for these services without a referral. Title V, Commission for Children with Special Health Care Needs are receiving comprehensive case management services.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Surveys
-Enrollee Hotlines
-Ombudsman
-Provider Data

Consumer Self-Report Data

None

Use of Collected Data:

-Beneficiary Provider Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

MAINE

MaineCare Primary Care Case Management

CONTACT INFORMATION

State Medicaid Contact:

Brenda McCormick
Bureau of Medical Services
(207) 287-1774

State Website Address:

HTTP://www.state.me.us/bms/bmshome.htm

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Public Consulting Group, Inc.

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Ambulatory Surgical Center, Certain Family Planning, Chiropractic, Clinic (FQHC & RHC), Developmental & Behavioral Evaluation Clinic, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Medical Supplies, Occupational Therapy, Outpatient Hospital, Physical Therapy, Physician, Podiatric, Speech/Language Pathology, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners
-Physician Assistants
-Ambulatory Care Clinic or Hospital Based Outpatient Clinic

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

- -Participate in HCBS Waiver
- -Individuals on Medicaid recipient restriction program
- -Individuals eligible for SSI
- -Individuals under 19 with special health care needs
- -Katie Beckett Eligibles
- -Special Needs Children (State defined)
- -Special Needs Children (BBA defined)
- -Medicare Dual Eligible
- -Other Insurance
- -Reside in Nursing Facility or ICF/MR
- -Eligibility Period Less Than 3 Months

-TITLE XXI SCHIP
-Pregnant Women

Lock-In Provision:

12 months lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

MaineCare Primary Care Case Management

ADDITIONAL INFORMATION

Included Services: Certain family planning services and family planning are different in the sense that all family planning services are exempt when provided in a family clinic. Certain family planning services generally refers to services in other setting such as a physicians office.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- -Consumer Self-Report Data
- -Enrollee Hotlines
- -Focused Studies
- -Ombudsman
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)
- -Provider Data

Consumer Self-Report Data

- -Disenrollment Survey
- -State-developed Survey

Use of Collected Data:

- -Beneficiary Provider Selection
- -Health Services Research
- -Monitor Quality Improvement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Provider Profiling
- -Regulatory Compliance/Federal Reporting
- -Track Health Service provision

Performance Measures

MAINE

MaineCare Primary Care Case Management

Process Quality

-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Dental services
-Diabetes management/care
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Influenza vaccination rate
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Access/Availability of Care

-Average distance to primary care case manager
-Ratio of primary care case managers to beneficiaries

Provider Characteristics

-Languages spoken (other than English)

Health Status/Outcomes Quality

-Patient satisfaction with care

Use of Services/Utilization

-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Beneficiary Characteristics

-Beneficiary need for interpreter
-Disenrollment rate
-Percentage of beneficiaries who are auto-assigned to PCCM
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

Performance Improvement Projects

Clinical Topics

-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management
-Emergency Room service utilization
-Lead toxicity
-Medical problems of the frail elderly
-Otitis Media management
-Pharmacy management
-Pre-natal care
-Presciption drug abuse
-Prevention of Influenza
-Smoking prevention and cessation
-Well Child Care/EPSDT

Non-Clinical Topics

-Availability of language interpretation services
-Children's access to primary care practitioners

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1932(a)

CONTACT INFORMATION

State Medicaid Contact:

David Cygan
Nebraska Medicaid
(402) 471-9050

State Website Address:

http://www.hhss.state.ne.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Nebraska Health Connection/Access Medicaid

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Transportation, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Presumptive Eligibles
-Transplant Recipients
-Women with Cancer
-Special Needs Children (BBA defined)

Lock-In Provision:

1 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Transportation, Vision, X-Ray

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:

None

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Clients with Excess Income
-Clients Participating in the Subsidized Adoption Program
-Clients Participating in the State Disability Program
-Presumptive Eligibility
-Transplant Recipients
-Women with Cancer
-Special Needs Children (BBA defined)

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1932(a)

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Title V Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Primary Care Plus

Share Advantage

ADDITIONAL INFORMATION

Children on SSI, Children in Foster Care or Out-of-Home Placements, and Children Eligible For and Receiving Title V Services.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Participation (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-Consumer/Beneficiary Focus Groups
-State-developed Survey

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Asthma care - medication use
-Check-ups after delivery
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Average distance to PCP

Use of Services/Utilization
None

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
-Beneficiary need for interpreter
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance

Clinical Topics
-(Newborn) Failure to thrive
-Low birth-weight baby

improvement project(s) prescribed by State Medicaid agency

-Pre-natal care

Non-Clinical Topics
None

Standards/Accreditation

MCO/PIHP/PAHP Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation for Deeming
None

EQRO Organization
-QIO-like entity

Accreditation Required for Participation
-Department of Insurance Certification
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Nebraska Foundation for Medical Care

EQRO Mandatory Activities
-Validation of performance improvement projects

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:
-Beneficiary Provider Selection
-Contract Standard Compliance
-Fraud and Abuse
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data
-Consumer/beneficiary Focus Groups
-State-developed Survey

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visits rates
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
None

Access/Availability of Care
-Average distance to primary care case manager
-Children's access to primary care practitioners
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
None

NEBRASKA

Nebraska Health Connection Combined Waiver Program - 1932(a)

Provider Characteristics

-Languages spoken (other than English)
-Provider turnover

Beneficiary Characteristics

-Beneficiary need for interpreter
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM
-Weeks of pregnancy at time of enrollment in PCCM, for women giving birth during the reporting period

NEVADA

Mandatory Health Maintenance Program

CONTACT INFORMATION

State Medicaid Contact:

Mary Pennington
Division of Health Care Financing and Policy
(775) 684-3698

State Website Address:

http://www.state.nv.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
December 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practioner, Chiropactor, Dental, Disposable Medical Supplies, Durable Medical Equipment, Emergency Transportation, End Stage Renal Disease Facilities, EPSDT, Family Planning, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Intravenous Therapy, Laboratory, Medical Rehabilitation Center, Mental Health Rehabilitative, Noninvasive Diagnostic Centers, Nurse Anesthetist, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Physician Assistants, Podiatrist, Prosthetics, Pyschologist, Respiratory Therapy, Rural Health Clinics, Skilled Nursing Facility, Special Clinics, Speech Therapy, Transitional Rehabilitative Center, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

NEVADA
Mandatory Health Maintenance Program

Populations Voluntarily Enrolled:
- -Severely Emotionally Disabled Children
- -Seriously Mentally Ill Adults
- -Children with Special Health Care Needs
- -American Indian

Subpopulations Excluded from Otherwise Included Populations:
- -Children - Inpatients at Residential Treatment Facility
- -Medicare Dual Eligible
- -Other Insurance
- -Special Needs Children (BBA defined)
- -Residents in Nursing Facilities beyond 45 Days

Populations Mandatorily Enrolled:
- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- -Reviews complaints and grievances to identify members of these groups
- -Surveys medical needs of enrollee to identify members of these groups
- -Uses eligibility data to identify members of these groups
- -Uses enrollment forms to identify members of these groups
- -Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Maternal and Child Health Agency
- -Mental Health Agency
- -Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Plan of Nevada

NevadaCare DBA Nevada Health Solutions

ADDITIONAL INFORMATION

For the Mandatory Program, Temporary Assistance for Needy Families/Child Health Assurance Program, Severely Emotionally Disturbed Children, Seriously Mentally Ill Adults, Children with Special Health Care Needs and American Indians are provided voluntary enrollment and/or disenrollment at any time.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- -Accreditation for Deeming (see below for details)
- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -Focused Studies
- -MCO/PIHP/PAHP Standards (see below for details)
- -Monitoring of MCO/PIHP/PAHP Standards
- -On-Site Reviews
- -Performance Measures (see below for details)

Use of Collected Data
- -Contract Standard Compliance
- -Monitor Quality Improvement
- -Plan Reimbursement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting
- -Track Health Service provision

-Provider Data

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Adolescent well-care visit rates
-Dental services
-Immunizations for two year olds

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care

-Ratio of dental providers to beneficiaries
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Beneficiary Characteristics

-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Use of Services/Utilization

-Drug Utilization
-Inpatient admissions/1,000 beneficiary
-Number of PCP visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit

Health Plan/ Provider Characteristics

-Board Certification

Standards/Accreditation

MCO/PIHP/PAHP Standards

-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-NAIC (National Association of Insurance Commissioners) Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation for Deeming

-NCQA (National Committee for Quality Assurance)

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-Health Services Advisory Group

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities

-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

NEVADA
Voluntary Health Maintenance Program

CONTACT INFORMATION

State Medicaid Contact:	Mary Pennington Division of Health Care Financing & Policy (775) 684-3698
State Website Address:	http://www.state.nv.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Ambulatory Surgery Center, Case Management, Certified Registered Nurse Practioner, Chiropractor, Disposable Medical Supplies, Durable Medical Equipment, Emergency Transportation, End Stage Renal Disease Facilities, EPSDT, Family Planning, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Intravenous Therapy, Laboratory, Medical Rehabilitation Center, Mental Health Rehabilitative Service, Noninvasive Diagnostic Center, Nurse Anesthetist, Nurse Midwife, Occupational Therapy, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physical Therapy, Physician, Physician Assistant, Podiatrist, Prosthetics, Psychologist, Respiratory Therapy, Rural Health Clinic, Skilled Nursing Facility, Special Clinics, Speech Therapy, Transitional Rehabilitative Center, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

NEVADA

Voluntary Health Maintenance Program

Populations Voluntarily Enrolled:

- Section 1931 (AFDC/TANF) Children and Related Populations
- Section 1931 (AFDC/TANF) Adults and Related Populations
- Severely Emotionally Disturbed Children
- Seriously Mentally Ill Adults
- Children with Special Health Care Needs
- American Indian

Subpopulations Excluded from Otherwise Included Populations:

- Medicare Dual Eligible
- Inpatients in Residential Treatment Facilities
- Residents in Nursing Facilities beyond 45 Days
- Special Needs Children (BBA defined)
- Other Insurance

Populations Mandatorily Enrolled:

None

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Reviews complaints and grievances to identify members of these groups
- Surveys medical needs of enrollee to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Maternal and Child Health Agency
- Mental Health Agency
- Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

NevadaCare DBA Nevada Health Solutions

ADDITIONAL INFORMATION

This program only includes beneficiaries in Washoe county.

NEW JERSEY

New Jersey Care 2000+ (1932)

CONTACT INFORMATION

State Medicaid Contact:

Susan Welsh
Office of Quality Assurance
(609) 588-7379

State Website Address:

http://www.state.nj.us/humanservices/dmahs/index.h

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 1995

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Audiology, Chiropractor, Dental, Durable Medical Equipment/Assistive Technology Devices, Emergency Medical Care, EPSDT, Family Planning, Hearing Aid, Home Health, Hospice, Immunization, Inpatient hospital including acute care, rehabilitation and special hospitals, Laboratory, Medical Supplies, MH/SUD for enrollees who are clients of the Division of Developmental Disabilities, Optical Appliances, Optometrist, Organ Transplants, Outpatient Hospital, Pharmacy, Physician, Podiatrist, Post-acute care, Preventive Health Care and Counseling and Health Promotion, Prosthetics and Orthotics including certified shoe provider, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Family Practitioners
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Certified Nurse Specialists

Enrollment

NEW JERSEY

New Jersey Care 2000+ (1932)

Populations Voluntarily Enrolled:

-Foster Care Children
-Medicare Dual Eligible

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program without Department of Human Services Contract
-American Indian/Alaskan Native
-Participate in HCBS Waiver except DDD/CCW non-duals
-Special Needs Children (BBA defined)
-Institutionalized in inpatient psychiatric facility
-Medically needy and presumptive eligibility beneficiaries

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Non Dually Eligible Aged, Blind and Disabled Adults and Related Populations
-Non dual DDD/CCW (adults)

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriChoice of New Jersey, Inc.
Health Net
University Health Plans, Inc.
AMERIGROUP New Jersey, Inc.
Horizon Mercy

ADDITIONAL INFORMATION

Effective 4/1/00, 1932(a) program was amended to include SSI, Aged, Blind, Disabled, and Division of Developmental Disabilities Community Care Waiver (DDD/CCW) population. Contract to provide services to newly mandated population was not effective until 10/1/00. Phased-in Enrollment for the Aged, Blind,Disabled and DDD/CCW Population effective 10/01/2000. Lock-in Period: 12-month lock in is for AFDC/TANF and Title XXI population. There is no lock-in for SSI, Aged, Blind, Disabled and DDD and DFYS populations.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)

Use of Collected Data

-Contract Standard Compliance
-Health Services Research

-Enrollee Hotlines
-Focused Studies
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data
-CAHPS
Adult Medicaid AFDC Questionnaire
Survey-included ABD adult and children specific questions--results not separated by age group

-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Comparison of reported changes to reasonable and customary fees

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments
Yes

NEW JERSEY
New Jersey Care 2000+ (1932)

Performance Measures

Process Quality
-Adolescent immunization rate
-Adolescent well-care visit rates
-Analysis of pharmaceutical services
-Asthma care - medication use
-Breast Cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Quality and utilization of dental services
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries
-Ratio of pharmacies to number of beneficiaries

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Health Status/Outcomes Quality
-Lead Toxicity Study
-Member Satisfaction (CAHPS)
-Patient satisfaction with care

Use of Services/Utilization
-Average length of stay
-Emergency room visits/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Inpatient Days per 1000 Members
-Number of OB/GYN visits per adult female beneficiary
-Percentage of beneficiaries with at least one dental visit
-Pharmacy services per member
-Physician visits per 1000 members

Health Plan/ Provider Characteristics
None

Performance Improvement Projects

Project Requirements
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance

Clinical Topics
-Adolescent Well Care/EPSDT
-Asthma management

improvement project(s) prescribed by State Medicaid agency

-Breast cancer screening (Mammography)
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management/care
-Lead Screenings
-Postnatal care
-Prenatal Care
-Well Child Care/EPSDT

Non-Clinical Topics

-Adults access to preventive/ambulatory health services
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PIHP/PAHP Standards

None

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-PRONJ, The Healthcare Quality Improvement Organization of New Jersey, Inc.

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities

-Calculation of performance measures
-Conduct of performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Medical Record Review
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of encounter data

NORTH CAROLINA
Access II/III - 1932(a)

CONTACT INFORMATION

State Medicaid Contact:

Deborah Bowen
Division of Medical Assistance
(919) 857-4226

State Website Address:

http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Dialysis, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Outpatient Hospital, Personal Care, Physician, Private Duty Nursing, X-Ray

Allowable PCPs:
-Nurse Midwives
-Physician Assistants
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Health Departments
-Hospital Outpatient Clinics
-Community Health Centers
-Health Clinics
-Other Specialists Approved on a Case-by-Case Basis
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners

NORTH CAROLINA
Access II/III - 1932(a)

Enrollment

Populations Voluntarily Enrolled:
- -Pregnant Women
- -Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
- -Reside in Nursing Facility or ICF/MR
- -Eligibillity Period that is only Retroactive
- -Refugees
- -QMB
- -Special Needs Children (BBA defined)
- -Medicare Dual Eligible
- -American Indian/Alaskan Native

Populations Mandatorily Enrolled:
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- -Asks advocacy groups to identify members of these groups
- -Reviews complaints and grievances to identify members of these groups
- -Surveys medical needs of enrollee to identify members of these groups
- -Uses ACCESS II Health assessment form
- -Uses eligibility data to identify members of these groups
- -Uses enrollment forms to identify members of these groups
- -Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Maternal and Child Health Agency
- -Public Health Agency
- -Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access II/III

ADDITIONAL INFORMATION

An Administrative Entity is paid an additional PCCM case management fee of $2.50 per recipient participating in Access II/III to monitor care and implement disease management initiatives and target preventive studies. ACCESS II/III manages the highest risk Medicaid enrollees to improve coordination and continuity of care.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
- -Care Management
- -Consumer Self-Report Data
- -Enrollee Hotlines
- -Focused Studies

Use of Collected Data:
- -Contract Standard Compliance
- -Fraud and Abuse
- -Health Services Research
- -Monitor Quality Improvement

-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

-Plan and Provide Education
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Quality Improvement Activities
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
-Smoking Cessation Readiness

Performance Measures

Process Quality

-Asthma care - medication use
-Asthma Management
-Cholesterol screening and management
-Depression medication management
-Diabetes management/care
-Influenza vaccination rate
-Smoking prevention and cessation

Health Status/Outcomes Quality

-Asthma Management
-Cost of Medications
-Diabetes Management
-Inpatient admissions and ER visits
-Patient satisfaction with care

Access/Availability of Care

-After Hours and Weekend Availability
-Average wait time for an appointment with primary care case manager
-Complaint Monitering
-Ratio of primary care case managers to beneficiaries
-Ratio to Case Managers
-Satisfaction Survey

Use of Services/Utilization

-24 Hour Nurse Call Center Use
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Inpatient and ED admissions with diagnosis of Asthma or Diabetes
-Number of home health visits per benificiary
-Number of primary care case manager visits per beneficiary
-Number of specialist visits per beneficiary

Provider Characteristics

-Bilingual staff and educational materials in English and Spanish
-Languages spoken (other than English)
-Patient/family satisfaction and understanding services
-Provider turnover

Beneficiary Characteristics

-Beneficiary need for interpreter
-Complaints and Satisfaction Survey
-Disenrollment rate
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries
-Percentage of beneficiaries who are auto-assigned to PCCM
-Reason for disenrollment of change of PCP

Performance Improvement Projects

Clinical Topics

-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Cholesterol screening and management
-Coordination of primary and behavioral health care
-Deprssion management
-Diabetes management
-Emergency Room service utilization
-Low birth-weight baby
-Otitis Media management
-Pharmacy management
-Presciption drug abuse
-Prevention of Influenza

Non-Clinical Topics

-Adults access to preventive/ambulatory health services
-Availability of language interpretation services
-Collaboration and Integration of Wrap-Around Services
-Community Communication and Collaboration with High-Risk Clients

-Smoking prevention and cessation
-Treatment of Depression in PCP office Pilot

NORTH CAROLINA
Carolina ACCESS 1932(a)

CONTACT INFORMATION

State Medicaid Contact:	Deborah Bowen Division of Medical Assistance (919) 857-4226
State Website Address:	http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1999

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Chiropractic, Dialysis, Durable Medical Equipment, EPSDT, Hearing (Excludes Hearing Aids), Home Health, Immunization, Inpatient Hospital, Laboratory, Nurse Midwife, Outpatient Hospital, Personal Care, Physician, Private Duty Nursing, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Public Health Departments
-Community Health Centers
-Health Clinics
-Hospital Outpatient Clinics
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Physician Assistants
-Nurse Practitioners

NORTH CAROLINA
Carolina ACCESS 1932(a)

Enrollment

Populations Voluntarily Enrolled:

- Aged and Related Populations
- Medicaid Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

- Eligibility Period that is only Retroactive
- Reside in Nursing Facility or ICF/MR
- Enrolled in Another Managed Care Program
- Private Insurance and PCP not willing to participate
- American Indian/Alaskan Native
- Special Needs Children (BBA defined)
- Medicare Dual Eligible

Populations Mandatorily Enrolled:

- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Aged and Related Populations

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Reviews complaints and grievances to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Maternal and Child Health Agency
- Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Carolina Access

ADDITIONAL INFORMATION

The recipient must choose and enroll with or be assigned to a primary care provider who is paid a monthly case management fee of $1.00 for each enrollee in addition to regular fee for service payments. Enrollment Broker: Public Consulting Group, is only used in Mecklenburg County.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

- Enrollee Hotlines
- Focused Studies
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)
- Provider Data

Use of Collected Data:

- Beneficiary Provider Selection
- Contract Standard Compliance
- Health Services Research
- Monitor Quality Improvement
- Program Evaluation
- Program Modification, Expansion, or Renewal
- Provider Profiling
- Regulatory Compliance/Federal Reporting
- Track Health Service provision

Consumer Self-Report Data

None

NORTH CAROLINA
Carolina ACCESS 1932(a)

Performance Measures

Process Quality
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Initiation of prenatal care - timeliness of

Health Status/Outcomes Quality
-Percentage of low birth weight infants

Access/Availability of Care
-Adult access to preventive/ambulatory health services
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiaries
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiaries
-Number of Outpatient Visits per 1,000 beneficiaries
-Number of specialist visits per beneficiary

Provider Characteristics
None

Beneficiary Characteristics
-Change of PCP and Reason for Change
-Patient Education
-Percentage of beneficiaries who are auto-assigned to PCCM

Performance Improvement Projects

Clinical Topics
-Congestive Heart Failure Management
-Diabetes management
-Pre-natal care

Non-Clinical Topics
-Complaint Process

NORTH CAROLINA

Health Care Connection 1932(a)

CONTACT INFORMATION

State Medicaid Contact:	Deborah Bowen Division of Medical Assistance (919) 857-4226
State Website Address:	http://www.dhhs.state.nc.us/dma/

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Public Consulting Group

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Adult Preventative Medicine, Ambulance, Chiropractic, Clinic Services-Except for Mental Health and Substance Use Disorders, Diagnostic Services, Dialysis, Durable Medical Equipment, Emergency Room, EPSDT, Family Planning and Supplies, Hearing Aids, Home Health, Home Infusion Therapy, Hospice, Immunization, Inpatient Hospital- Except for Mental Health and Substance Use Disorders, Laboratory, Midwife, Occupational, Physical and Speech Therapies, Optical Supplies, Outpatient Hospital, Physician Services including Physician Assistants and Family Nurse Practitioners, Podiatry, Postpartum Newborn Home Visits--EPSDT, Maternal Assessment and Newborn Assessment, Private Duty Nursing, Prosthetics/Orthotics, Sterilization, Total Parenteral Nutrition, Vision, X-Ray

Allowable PCPs:
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Physician Assistants
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

NORTH CAROLINA

Health Care Connection 1932(a)

Populations Voluntarily Enrolled:

-Aged and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Eligibility Period That Is Only Retro-active
-Special Needs Children (BBA defined)
-American Indian/Alaskan Native
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Enrolled in Another Managed Care Program

Populations Mandatorily Enrolled:

-Pregnant Women
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Wellpath Select, Inc. dba Southcare

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

NORTH CAROLINA
Health Care Connection 1932(a)

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Adult Medicaid SSI Questionnaire
-Complaints/Grievances/Appeals

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Units of Service

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Breast Cancer screening rate
-Cervical cancer screening rate
-Diabetes management/care
-Percentage of beneficiaries who are satisfied with their ability to obtain care

Health Status/Outcomes Quality
-New Member Health Assessment
-Patient satisfaction with care

NORTH CAROLINA
Health Care Connection 1932(a)

Access/Availability of Care
-Adult's Access to Preventative Services
-Average wait time for an appointment with PCP
-Involuntary Disenrollments
-Non-authorized visits
-PCP Referral Denials
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics
-After Hours Survey
-Enrollment by Product Line
-Languages Spoken (other than English)
-Provider Satisfaction Survey
-Provider turnover

Beneficiary Characteristics
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs

Performance Improvement Projects

Project Requirements
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Diabetes management/care
-Pre-natal care

Non-Clinical Topics
-2003 Provider Satisfaction Survey
-Initial Health Assessment/Health Check Review

Standards/Accreditation

MCO/PIHP/PAHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-QARI (quality Assurance Reform Initiative)
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Medical Review of North Carolina
-Myers and Stauffers

EQRO Organization
-QIO-like entity
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Validation of client level data, such as claims and encounters
-Validation of encounter data

NORTH DAKOTA

North Dakota Access and Care Program

CONTACT INFORMATION

State Medicaid Contact:	Tom Solberg Department of Human Services, Medical Assistance (701) 328-1884
State Website Address:	http://lnotes.state.nd.us/dhs/dhsweb.nsf/ServicePa

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Chiropractic, Dental, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mid-level Practitioner, Non-Emergency Transportation, Nutritional, Occupational, Physical, and Speech Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Podiatry, Private Duty Nursing, Public Health Unit, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

-Optional Categorically Needy
-Medically Needy
-Poverty Level

Subpopulations Excluded from Otherwise Included Populations:

-Eligiblity Period that is only Retroactive
-Special Needs Children (BBA defined)
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Foster Care
-Refugee Assistance
-Adoption Assistance

Lock-In Provision:

6 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Chiropractic, Durable Medical Equipment, Emergency, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Mid-Level Practitioner, Non-Emergency Transportation, Nutritional, Occupational, Physical, and Speech Therapy, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Podiatry, Public Health Unit, Transportation, X-Ray

Allowable PCPs:

-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Physician Assistants
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medically Needy
-Foster Care
-Refugee Assistance
-Adoption Assistance
-Eligibility Period that is only Retroactive
-Special Needs Children (BBA defined)

Populations Mandatorily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Optional Categorically Needy
-Poverty Level

Lock-In Provision:

No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AltruCare

North Dakota Access and Care Program

NORTH DAKOTA

North Dakota Access and Care Program

ADDITIONAL INFORMATION

AltruCare is only offered in Grand Forks county. Program was converted from a 1915(a) to a 1932(a) on July 1, 2001.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-Health Plan Developed Survey with State Approval

Use of Collected Data

-Fraud and Abuse
-Monitor Quality Improvement
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

None

Collections: Submission Specifications

-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

No

Performance Measures

Process Quality

-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

-Well-child care visit rates in first 15 months of life

Access/Availability of Care

-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care

-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics

-MCO/PIHP/PAHP/PCP-specific disenrollment rate

Use of Services/Utilization

-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of OB/GYN visits per adult female beneficiary

Health Plan/ Provider Characteristics

-Number and Type of Services Provided

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics

-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Diabetes management/care
-Emergency Room service utilization
-Lead toxicity
-Low birth-weight baby
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics

-Children's access to primary care practitioners

Standards/Accreditation

MCO/PIHP/PAHP Standards

-State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-North Dakota Health Care Review

EQRO Mandatory Activities

-Yet to be determined

EQRO Optional Activities

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data:

-Beneficiary Provider Selection
-Health Services Research
-Monitor Quality Improvement

-Program Evaluation
-Program Modification, Expansion, or Renewal
-Provider Profiling
-Track Health Service provision

Consumer Self-Report Data
-State-developed Survey

Performance Measures

Process Quality
-Breast Cancer screening rate
-Cervical cancer screening rate
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Lead screening rate
-Well-child care visit rates in first 15 months of life

Access/Availability of Care
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Provider Characteristics
None

Health Status/Outcomes Quality
-Patient satisfaction with care

Use of Services/Utilization
None

Beneficiary Characteristics
None

SOUTH DAKOTA
PRIME

CONTACT INFORMATION

State Medicaid Contact:

Scott Beshara
Office of Medical Services
(605) 773-3495

State Website Address:

http://www.state.sd.us/Social/Medicaid/

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Hearing, Home Health, Inpatient Hospital, Inpatient Mental Health, Laboratory, Opthalmology, Outpatient Hospital, Outpatient Mental Health, Physician, Residential Treatment Centers, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

SOUTH DAKOTA
PRIME

-TITLE XXI SCHIP
-Pregnant Women

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Special Needs Children (BBA defined)

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Provider contacts - Medically fragile protocol
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

PRIME

ADDITIONAL INFORMATION

None

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:

-Consumer Self-Report Data
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

-State-developed Survey

Use of Collected Data:

-Beneficiary Provider Selection
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Provider Profiling

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

None

SOUTH DAKOTA
PRIME

Access/Availability of Care
-Average distance to primary care case manager
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
None

Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Asthma management
-Breast cancer screening (Mammography)
-Cervical cancer screening (Pap Test)
-Childhood Immunization
-Low birth-weight baby
-Well Child Care/EPSDT

Non-Clinical Topics
None

UTAH
Voluntary PCP/PIHP Program

CONTACT INFORMATION

State Medicaid Contact:

Julie Olson
Division of Health Care Financing
(801) 538-6358

State Website Address:

http://health.utah.gov/medicaid

PROGRAM DATA

Program Service Area:
County

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 2000

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, EPSDT, Family Planning, Immunization, Physician

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

Populations Mandatorily Enrolled:
None

- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations
- -Foster Care Children
- -Pregnant Women
- -Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

- -Reside in Nursing Facility or ICF/MR
- -During Retroactive Eligibility Period
- -Reside in State Hospital or in State Developmental Center
- -Special Needs Children (BBA defined)

Lock-In Provision:

1 month lock-in

Medical-only PIHP (non-risk, comprehensive) - Fee-for-Service

Service Delivery

Included Services:

Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Physician, Vision, X-Ray

Allowable PCPs:

- -Pediatricians
- -General Practitioners
- -Family Practitioners
- -Internists
- -Obstetricians/Gynecologists
- -Nurse Practitioners
- -Nurse Midwives
- -Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:

- -Section 1931 (AFDC/TANF) Children and Related Populations
- -Section 1931 (AFDC/TANF) Adults and Related Populations
- -Blind/Disabled Adults and Related Populations
- -Blind/Disabled Children and Related Populations
- -Aged and Related Populations
- -Foster Care Children
- -Pregnant Women
- -Special Needs Children (State defined)

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

- -Reside in Nursing Facility or ICF/MR
- -During Retroactive Eligibility Period
- -Reside in State Hospital or in the State Developmental Center

Lock-In Provision:

1 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- -Uses eligibility data to identify members of these groups
- -Uses provider referrals to identify members of these

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Aging Agency
- -Developmental Disabilities Agency

groups

-Maternal and Child Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Molina Healthcare of Utah (AFC Plus)	Voluntary PCP/PIHP Program

ADDITIONAL INFORMATION

A child under age 21 who has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who is blind or disabled or in a related population, is in foster care or other out-of-home placement, is receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of title V.

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Provider Data

Consumer Self-Report Data
-CAHPS
    Adult Medicaid AFDC Questionnaire
    Adult Medicaid SSI Questionnaire
    Adult with Special Needs Questionnaire
    Child Medicaid AFDC Questionnaire
    Child Medicaid SSI Questionnaire
    Child with Special Needs Questionnaire

Use of Collected Data:
-Contract Standard Compliance
-Fraud and Abuse
-Provider Profiling

WISCONSIN
Medicaid HMO Program

CONTACT INFORMATION

State Medicaid Contact:

Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:

http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
1932 - State Plan Option to Use Managed Care

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
12 months guaranteed eligibility for children

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 31, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
Not Applicable

Sections of Title XIX Costs Not Otherwise Matchable Granted:
Not Applicable

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Pediatricians
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers

Enrollment

Populations Voluntarily Enrolled:
None

Populations Mandatorily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Pregnant Women

WISCONSIN
Medicaid HMO Program

Subpopulations Excluded from Otherwise Included Populations:

-American Indian/Alaskan Native
-Residents residing in FFS counties
-Migrant workers
-Special Needs Children (BBA defined)
-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency (County departments)
-Mental Health Agency (County departments)
-Public Health Agency (County departments)
-Social Services Agency (County departments)
-Substance Abuse Agency (County departments)

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Atrium Health Plan -- Medicaid HMO
Group Health Cooperative Of Eau Claire -- Medicaid HMO
Health Tradition Health Plan -- Medicaid HMO
MercyCare Insurance Company -- Medicaid HMO
Security Health Plan -- Medicaid HMO
UnitedHealthcare of WI -- Medicaid HMO
Valley Health Plan -- Medicaid HMO
Dean Health Plan -- Medicaid HMO
Group Health Cooperative Of South Central WI -- Medicaid HMO
Managed Health Services -- Medicaid HMO
Network Health Plan -- Medicaid HMO
Touchpoint Health Plan -- Medicaid HMO
Unity Health Insurance -- Medicaid HMO

ADDITIONAL INFORMATION

The Wisconsin Medicaid HMO program started in 1977 with voluntary enrollment in three urban counties. The program changed to mandatory enrollment in 1984, and expanded into additional counties in 1994 and 1995. The program began to phase in statewide coverage in 1996 and completed the statewide expansion in March 1997. After the 1997 Balanced Budget Act changed the waiver rules, the program authority was converted from a 1915(b) waiver to a 1932(a) state plan managed care option on 04/01/1999.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Health Services Research
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of "home grown" forms
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Admission source
-Admission type
-Days supply
-Modifier codes
-Patient status code
-Place of service codes
-Quantity

State conducts general data completeness assessments

Yes

Performance Measures

WISCONSIN
Medicaid HMO Program

Process Quality
-Breast Cancer screening rate
-Cervical cancer screening rate
-Children with at least one comprehensive EPSDT well child visit in the look-back period at age 3-5 years, 6-14years, and 15-20 years
-Children with at least one non-EPSDT well-child visit in the look-back period at ages birth-1 year, 1-2 years, 3-5 years, 6-14years and 15-20 years
-Comprehensive EPSDT well-child visits for children age birth to two years for those receiving 5, 6 and 7 or more visits
-Dental services
-Diabetes medication management
-Follow-up after hospitalization for mental illness
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age

Health Status/Outcomes Quality
-Breast malaignancies detected
-Cervix/uterus malignancies detected
-HPV infections detected
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP
-Provider network data on geographic distribution.
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
-AAAHC (Accreditation Association for Ambulatory Health Care)
-All accrediting body standards are subject to review/acceptance for deeming
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
-NCQA (National Committee for Quality Assurance)

EQRO Name
-MetaStar

WISCONSIN
Medicaid HMO Program

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

Section:
1915(a) - Voluntary Programs

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ALABAMA
Partnership Hospital Program

CONTACT INFORMATION

State Medicaid Contact:

Lynn Sharp
Alabama Medicaid Agency
(334) 242-5588

State Website Address:

http://www.medicaid.state.al.us

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
Voluntary - No Authority/Section 1902(a)(4)

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP - Full Capitation

Service Delivery

Included Services:
Inpatient Hospital

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:
-Medicare Dual Eligible

Populations Mandatorily Enrolled:
None

Lock-In Provision:
Does not apply because State only contracts with one

-Poverty Level Pregnant Woman

managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Reviews complaints and grievances to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Partnership Hospital Program

ADDITIONAL INFORMATION

Section 1902(a)(4) requires that States provide for methods of administration that the Secretary finds necessary for proper and efficient operations of State Medicaid plan. The application of the requirements of this part to PIHPs that do not meet the statutory definition of MCO or to a PCCM is under the authority in Section 1902(a)(4).

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies

Use of Collected Data

-Monitor Quality Improvement

Consumer Self-Report Data

None

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)

Collections: Submission Specifications

None

Collection: Standardized Forms

None

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Procedure Codes

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Alabama Quality Assurance Foundation

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities

CALIFORNIA
Prepaid Health Plan Program

CONTACT INFORMATION

State Medicaid Contact:

Luis Rico
Medi-Cal Managed Care Division
(916) 449-5000

State Website Address:

http://www.dhs.ca.gov

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
1) Health Care Options for Marin County
2) Partners for Health Managed Care Network for Sonoma County

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1972

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Nurse Practitioners
-Nurse Midwives

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

-Foster Care Children
-Section 1931 (CALWORKS/TANF) Children and Related Populations
-Section 1931 (CALWORKS/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver

Lock-In Provision:

No lock-in

Dental PAHP - Full Capitation

Service Delivery

Included Services:

Dental

Allowable PCPs:

-Dentists

Enrollment

Populations Voluntarily Enrolled:

-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-Section 1931 (CALWORKS/TANF) Children and Related Populations
-Section 1931 (CALWORKS/TANF) Adults and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Populations residing outside plans service area defined by contract

Populations Mandatorily Enrolled:

None

Lock-In Provision:

No lock-in

PAHP (Only for Emotional Support) - Full Capitation

Service Delivery

Included Services:
Emotional Support

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Mental Health

Subpopulations Excluded from Otherwise Included Populations:
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Period Less Than 3 Months
-Participate in HCBS Waiver

Populations Mandatorily Enrolled:
None

Lock-In Provision:
No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Access Dental Plan
Care 1st Health Plan-Dental PHP
UHP Healthcare-Dental
Western Dental Services
American Health Guard-Dental Plan
Kaiser Foundation (North)
Universal Care-Dental

ADDITIONAL INFORMATION

San Francisco City under this program only provides emotional support to severely emotionally disturbed children.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Does Not Collect Quality Data

Use of Collected Data
-Not Appicable

Consumer Self-Report Data
None

Use of HEDIS
-Not Applicable

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-Not Applicable

Accreditation Required for Participation
None

EQRO Name
-Not Appicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
-Not Appicable

COLORADO
Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Katie Brookler
Dept. of Health Care Policy and Financing
(303) 866-4654

State Website Address:

http://www.CHCPF.state.co.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
MAXIMUS, INC.

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 1983

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

PCCM Provider - Fee-for-Service

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations

Populations Mandatorily Enrolled:
None

-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations
-Foster Care Children
-Medicare Dual Eligible

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Presumptive Eligible

Lock-In Provision:

12 month lock-in

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:

Case Management, Durable Medical Equipment, Emergency Transportation, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Skilled Nursing Facility, Vision, X-Ray

Allowable PCPs:

-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Presumptive Eligible

Lock-In Provision:

12 month lock-in

COLORADO
Managed Care Program

Medical-only PIHP (non-risk, comprehensive) - Partial Capitation

Service Delivery

Included Services:
Case Management, Durable Medical Equipment, EPSDT, Family Planning, Home Health, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Federally Qualified Health Centers (FQHCs)
-Rural Health Clinics (RHCs)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Foster Care Children
-American Indian/Alaskan Native

Subpopulations Excluded from Otherwise Included Populations:
-No populations are excluded

Populations Mandatorily Enrolled:
None

Lock-In Provision:
12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
-Developmental Disabilities Agency
-Mental Health Agency
-Social Services Agencies

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Colorado Access
Rocky Mountain HMO
Primary Care Physician Program

ADDITIONAL INFORMATION

Program was converted from a 1915(b) to a 1915(a) on May 1, 2003. The Primary Care Physician Program is a primary care case management managed care program available statewide which provides beneficiaries the option of a fee-for-service physician who acts as a gatekeeper and refers for specialty care. HMO option and PIHP options are available and varies by county.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Accreditation for Deeming (see below for details)
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting

Consumer Self-Report Data

-CAHPS
    Adult Medicaid AFDC Questionnaire
    Child Medicaid AFDC Questionnaire
-Children with Chronic Conditions

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data ALL of the HEDIS measures listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Encounter Data

Collection: Requirements

-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

None

Validation: Methods

-Quality Assurance
-Risk Adjustments

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

None

State conducts general data completeness assessments

No

Performance Measures

Process Quality

-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Diabetes medication management
-Hearing services for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Number of adults who receive exams
-Percentage of beneficiaries who are satisfied with their

Health Status/Outcomes Quality

-Patient satisfaction with care

ability to obtain care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care
-Adult's access to preventive/ambulatory health services
-Average wait time for an appointment with PCP
-Children's access to primary care practitioners
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Adult hearing and vision screening
-Asthma management
-Breast cancer screening (Mammography)
-Breast cancer treatment
-Cervical cancer screening (Pap Test)
-Cervical cancer treatment
-Child/Adolescent Dental Screening and Services
-Child/Adolescent Hearing and Vision Screening and Services
-Childhood Immunization
-Diabetes management/care
-Well Child Care/EPSDT

Non-Clinical Topics
-Children's access to primary care practitioners

Standards/Accreditation

MCO/PIHP/PAHP Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation Required for Participation
None

Accreditation for Deeming
-NCQA (National Committee for Quality Assurance)

EQRO Name
-Health Services Advisory Group

EQRO Organization
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of

clinical or non-clinical services
-Validation of client level data, such as claims and encounters

QUALITY ACTIVITIES FOR PCCM/OTHER SERVICE DELIVERY SYSTEMS

Quality Oversight Activities:
-Consumer Self-Report Data
-Enrollee Hotlines
-Focused Studies
-Ombudsman
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data:
-Monitor Quality Improvement

Consumer Self-Report Data
-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
  Child with Special Needs Questionnaire

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Chlamydia screening in women
-Diabetes management/care
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Smoking prevention and cessation
-Well-child care visit rates in 3, 4, 5, and 6 years of life
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average wait time for an appointment with primary care case manager
-Ratio of primary care case managers to beneficiaries

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

Provider Characteristics
None

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-Information on primary languages spoken by beneficiaries

Performance Improvement Projects

Clinical Topics
-Adolescent Immunization
-Adolescent Well Care/EPSDT
-Childhood Immunization
-Pre-natal care
-Well Child Care/EPSDT

Non-Clinical Topics
-Availability of language interpretation services

DISTRICT OF COLUMBIA
Health Services for Children with Special Needs

CONTACT INFORMATION

State Medicaid Contact:	Maude Holt Dept. of Health, Medical Assistance Administrator (202) 442-9074
State Website Address:	http://www.dchealth.com

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
ACS,Inc

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
February 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP (non-risk, comprehensive) - Partial Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Most Medicaid Services, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricans/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

-Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Other Insurance
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Eligibility Less Than 3 Months
-Participate in HCBS Waiver
-American Indian/Alaskan Native

Lock-In Provision:

12 month lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Asks advocacy groups to identify members of these groups
-Reviews complaints and grievances to identify members of these groups
-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups
-Uses enrollment forms to identify members of these groups
-Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Maternal and Child Health Agency
-Mental Health Agency
-Social Services Agency
-Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Health Services For Children with Special Needs

ADDITIONAL INFORMATION

This is no longer a demonstration program but a cost-base reimbursement program and there is no risk involved for providers. Skilled Nursing Facility for first 30 days. Program provides Emergency Transportation only. Under the new contract, children with special needs are defined as "Those children who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond those required by children generally. This definition includes children on SSI or who are SSI-related eligibles".

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)

Use of Collected Data

-Beneficiary Plan Selection
-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement

-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Measures (see below for details)
-Provider Data

Consumer Self-Report Data

None

-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms

-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods

-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Comparison to benchmarks and norms (e.g. comparisons to State FFS utilization rates, comparisons to MCO/PIHP/PAHP commercial utilization rates, comparisons to national norms, comparisons to submitted bills
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments

Yes

Performance Measures

DISTRICT OF COLUMBIA
Health Services for Children with Special Needs

Process Quality
-Adolescent immunization rate
-Check-ups after delivery
-Dental services
-Depression management/care
-Diabetes medication management
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries with at least one dental visit
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care
-Ratio of dental providers to beneficiaries
-Ratio of mental health providers to number of beneficiaries

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care
-Net income
-Net worth
-Total revenue

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
None

Standards/Accreditation

MCO/PIHP/PAHP Standards
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations) Standards
-NCQA (National Committee for Quality Assurance) Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Delmarva Foundation for Medical Care

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance measures

EQRO Optional Activities
-Administration or validation of consumer or provider surveys
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

ILLINOIS
Voluntary Managed Care

CONTACT INFORMATION

State Medicaid Contact:

Anne Marie Murphy
Illinois Department of Public Aid
(217) 782-2570

State Website Address: http://www.dpaillinois.com

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
November 01, 1974

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Assistive/Augmentative Communication Devices, Audiology Services, Physical Therapy, Occupational Therapy, Speech Therapy, Behavioral Health, Blood and Blood Components, Certified Hospice, Chiropractic, Clinic, Diagnosis and treatment of medical conditions of the eye, Durable and nondurable medical equipment and supplies, Emergency Services, EPSDT, Family Planning, Home Health, Inpatient Hospital, Inpatient Psychiatric Care, Laboratory and x-ray services, Medical procedures performed by a dentist, Nurse Midwives, Orthotic/Prosthetic Devices, Outpatient Hospital, Pharmacy, Physician services, Psychiatric Care, Podiatric, Skilled Nursing Facility, Transportation

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

ILLINOIS

Voluntary Managed Care

Populations Voluntarily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP

Subpopulations Excluded from Otherwise Included Populations:

-Spenddown Eligibles
-Department of Children and Family Services Wards
-Non-citizens only receiving emergency services
-Healthy Start Eligibles
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Medicare Dual Eligible
-Other Insurance

Populations Mandatorily Enrolled:

None

Lock-In Provision:

No lock-in

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Amerigroup Illinois Inc.
Harmony Health Plan
United HealthCare of Illinois
Family Health Network
Humana Health Plan

ADDITIONAL INFORMATION

Nursing facility services are provided up to 90 days annually.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-CAHPS
  Adult Medicaid AFDC Questionnaire
  Child Medicaid AFDC Questionnaire
-Modified CAHPS Survey

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measures, but plans to generate SOME or ALL of the HEDIS measures listed for Medicaid in the future
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of

-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission
acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-IDPA - approved electronic flat file for transmitting pharmacy encounters
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Validation: Methods

-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Behavioral health utilization statistics
-Follow-up after hospitalization for mental illness
-Follow-up after hospitalization for substance abuse
-Frequency of on-going prenatal care
-Health history/physicals
-Hearing screenings for individuals less than 21 years of age
-Immunizations for two year olds
-Initiation of prenatal care
-Lead screening rate
-Vision screenings for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality

-Patient satisfaction with care
-Percentage of low birth weight infants

Access/Availability of Care

-Average wait time for an appointment with PCP
-Network adequacy of specialists, pharmacies, hospitals and other ancillary providers
-Ratio of PCPs to beneficiaries

Use of Services/Utilization

-Average number of visits to MH/SUD providers per beneficiary
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility
-Re-admission rates of MH/SUD

Health Plan Stability/ Financial/Cost of Care

-Actual reserves held by plan
-Medical loss ratio
-Net income
-Net worth

Health Plan/ Provider Characteristics

-Admitting and delivery privileges
-Provider license number
-Specialty of providers

-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics

-MCO/PIHP/PAHP/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards

-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare
-State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

-QIO-like entity

Accreditation Required for Participation

None

EQRO Name

-HealthSystems of Illinois

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State

EQRO Optional Activities

-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities

MICHIGAN
Childrens Special Health Care Services

CONTACT INFORMATION

State Medicaid Contact:

Katherine Stiffler
Michigan Department of Community Health
(517) 241-7186

State Website Address:

http://www.michigan.gov

PROGRAM DATA

Program Service Area:
38 counties

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Michigan Enrolls

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
Continuous eligibility for children under age 19

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Additional Continuity of Care Requirement, Care Coordination, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Individualized Care Planning, Inpatient Hospital, Laboratory, Maternal and Infant Support, Outpatient Hospital, Outpatient Mental Health, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Other Specialists Approved on a Case-by-Case Basis
-Pediatricians
-Most Pediatric Sub Specialists
-Some General Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Foster Care Children
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

-When Medically Eligible
-Section 1931 (AFDC/TANF) Children with CHCS coverage who may or may not have Medicaid or MiChild cov

Subpopulations Excluded from Otherwise Included Populations:

-Reside in nursing facility, ICF/MR, incarcerated, or MA spenddown

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Beneficiaries are already identified as special needs as eligibility in the program

Agencies with which Medicaid Coordinates the Operation of the Program:

-Education Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Childrens Choice of Michigan

Kids Care of Michigan

ADDITIONAL INFORMATION

The Children Special Health Services Program serves children who have qualifying conditions under CSHCS. The special needs are the focal point of services versus primary care. The operating authority for this program is Title V of the SSA pa 368 of 1978. Under this program, the State prior authorizes managed care services and providers for these children under two service delivery options either FFS or enrollment in one of two special health plans. The two special health plans that provide services under this program are incorporated, but not licensed in MI and therefore do not provide services to the commercial population.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data

Use of Collected Data

-Collected data will be used for assurance of appropriate care and to identify trends

Consumer Self-Report Data

-CAHPS
  add-on survey for special needs
-Consumer/Beneficiary Focus Groups
-Satisfaction survey for SHP enrollees
-Survey for new enrollees and follow-up at 6 months
-Survey for people who have lost coverage

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-County
-Zip code

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
None

Access/Availability of Care
-Access to buildings
-Average wait time for an appointment with PCP

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-State minimum reserve requirements

Beneficiary Characteristics
None

Health Status/Outcomes Quality
None

Use of Services/Utilization
None

Health Plan/ Provider Characteristics
-Board Certification
-Experience with pediatric care of special needs population
-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct

their own choosing

common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Delmarva

EQRO Mandatory Activities
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities
-Delmarva reviewed general CSHCS population, asthma, and CP population
-Planning for Delmarva to review general CSHCS population, asthma, and CP population

MINNESOTA
Minnesota Disability Health Options (MnDHO)

CONTACT INFORMATION

State Medicaid Contact:

Mary Kennedy
Minnesota Department of Human Services
(651) 282-9921

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
September 01, 2001

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Medicare Services Under Parts A & B, Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home and Community-Based Waiver, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nursing Facility Are Covered for 180 Days, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Blind or Disabled, Age 16 through 64, Dually Eligible for Medicaid and Medicare

Populations Mandatorily Enrolled:
None

MINNESOTA

Minnesota Disability Health Options (MnDHO)

Subpopulations Excluded from Otherwise Included Populations:

-Other Insurance
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-Reside in Regional Treatment Center
-QMB or SLMB, Not Otherwise Eligible for Medicaid
-Eligible for Medicare Part A or Part B Only

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medica
UCARE
Metropolitan Health Plan

ADDITIONAL INFORMATION

Contractors are not required to identify PCPs. PCP provider types are designated by HMOs rather than State. Health plans have been encouraged to develop networks with professionals with geriatric experience. Children participating in the Minnesota Department of Health Administered Program For Children With Special Health Needs Under Title V of the Social Security Act.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Care System Reviews
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-CAHPS
    Adult Medicaid Questionaire
-Disenrollment Survey
-State-Developed Survey for Nursing Home Enrollees/Families

Use of Collected Data

-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

MINNESOTA
Minnesota Disability Health Options (MnDHO)

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Ad hoc comparison to benchmarks and norms
-Ad hoc per member per month analysis and comparison across MCOs/PIHPs/PAHPs
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Limited analysis of encounter data submissions to help determine data completeness

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Cholesterol screening and management
-Diabetes management/care
-Influenza Vaccination Rate
-Timeliness of HCBS Reassessments
-Use of Home andCommunity-Based Services
-Use of Nursing Home Days

Access/Availability of Care
-Average distance to PCP
-Number of PCP Ambulatory Visits

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Medical loss ratio

Health Status/Outcomes Quality
-Family Satisfaction with Care - Nursing Home Members
-Patient satisfaction with care

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Use of Home Health Care/1000 Beneficiaries

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

-Net income
-State minimum reserve requirements
-Total revenue
-Provider turnover

Beneficiary Characteristics
-MCO/PIHP/PAHP/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Clinical Topics
-Congestive Heart Failure Management
-Diabetes management/care
-Optimal Medication Management
-Prevention of Influenza and Pneumonia

Non-Clinical Topics
None

Standards/Accreditation

MCO/PIHP/PAHP Standards
-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-FMAS (QIO-like)
-MetaStar (QIO)
-NCQA (Accreditation)
-PRS (QIO)
-Stratis Health (QIO)

EQRO Organization
-Private Accreditation Organization
-QIO-like entity
-Quality Improvement Organization (QIO)

EQRO Mandatory Activities
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services
-Coordination of QSMIC Collaboratives Between MSHO Health Plans
-Validation of client level data, such as claims and encounters

MINNESOTA
Minnesota Senior Health Options Program (MSHO)

CONTACT INFORMATION

State Medicaid Contact:

Mary Kennedy
Minnesota Department of Human Services
(651) 282-9921

State Website Address:

http://www.dhs.state.mn.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 01, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
All Medicare Services Under Parts A & B, Case Management, Dental, Durable Medical Equipment, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Nursing Facility Are Covered for 180 Days, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Services Available Under The Home And Community-Based Waiver, Skilled Nursing Facility, Transportation, Vision, X-Ray

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Age 65 or Older and Dually Eligible for Medicare and Medicaid, or Eligible for Medicaid without Medi

Populations Mandatorily Enrolled:
None

MINNESOTA

Minnesota Senior Health Options Program (MSHO)

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses eligibility data to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Aging Agency
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Medica
UCARE

Metropolitan Health Plan

ADDITIONAL INFORMATION

Contractors are not required to identify PCPs. PCP provider types are designated by HMOs rather than State; county staff perform enrollment functions. Health plans have been encouraged to develop networks with professionals with geriatric experience. MSHO provides one month rolling eligibility to provide coverage for enrollees who do not return a scheduled income or redetermination report on a timely basis. Children participating in the Minnesota Department of Health Administered Program For Children With Special Health Needs Under Title V of the Social Security Act.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Care System Reviews
-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Ombudsman
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

-Beneficiary Plan Selection
-Health Services Research
-Monitor Quality Improvement
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-CAHPS
    Adult Medicaid Questionaire
-Disenrollment Survey
-State-Developed Survey for Nursing Home Enrollees/Families

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

MINNESOTA

Minnesota Senior Health Options Program (MSHO)

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Ad hoc comparison to benchmarks and norms
-Ad hoc per member per month analysis and comparison across MCOs/PIHPs/PAHPs
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Limited automated analysis of encounter data submissions to help determine data completeness

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Cholesterol screening and management
-Diabetes management/care
-Influenza Vaccination Rate
-Timeliness of HCBS Reassessments
-Use of Home andCommunity-Based Services
-Use of Nursing Home Days

Access/Availability of Care
-Average distance to PCP
-Number of PCP Ambulatory Visits

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Medical loss ratio
-Net income

Health Status/Outcomes Quality
-Family Satisfaction with Care - Nursing Home Members
-Patient satisfaction with care

Use of Services/Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of days in ICF or SNF per beneficiary over 64 years
-Use of Home Health Care/1000 Beneficiaries

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

-State minimum reserve requirements
-Total revenue

Beneficiary Characteristics
-MCO/PIHP/PAHP/PCP-specific disenrollment rate

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-All MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by State Medicaid agency

Non-Clinical Topics

None

Clinical Topics

-Congestive Heart Failure Management
-Diabetes management/care
-Optimal Medication Management
-Prevention of Influenza and Pneumonia

Standards/Accreditation

MCO/PIHP/PAHP Standards

-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation for Deeming

None

EQRO Organization

-Private Accreditation Organization
-QIO-like entity
-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-FMAS (QIO-like)
-MetaStar (QIO)
-NCQA (Accreditation)
-PRS (QIO)
-Stratis Health (QIO)

EQRO Mandatory Activities

-Validation of performance measures

EQRO Optional Activities

-Coordination of QSMIC Collaboratives Between MSHO Health Plans
-Special Federal Projects on Dual Medicare-Medicaid Eligibles

NEW HAMPSHIRE

New Hampshire Voluntary Managed Care Program

CONTACT INFORMATION

State Medicaid Contact:

Jane Hybsch
State of New Hampshire Medicaid Agency
(603) 271-0275

State Website Address:

http://www.dhhs.state.nh.us

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
6 months guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 02, 1983

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, EPSDT, Family Planning, Hearing, Home Health, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Organ Transplant, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Physician, Skilled Nursing Facility, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children
-Section 1931 (AFDC/TANF) Adults and Related Populations
-TITLE XXI SCHIP
-Aid to Permanently and Totally Disabled up to age 21

Populations Mandatorily Enrolled:
None

Subpopulations Excluded from Otherwise Included Populations:

-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver
-In and Out beneficaries

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-Surveys medical needs of enrollee to identify members of these groups
-Uses enrollment forms to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Employment Agency
-Housing Agency
-Maternal and Child Health Agency
-Mental Health Agency
-Public Health Agency
-Social Services Agency
-Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Anthem Blue Cross/Blue Shield

ADDITIONAL INFORMATION

The SCHIP children aged 0-1 are enrolled voluntary. This program was terminated on 6/30/2003.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Enrollee Hotlines
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)
-Provider Data
-QCHIP Study

Consumer Self-Report Data

-Parent Satisfaction with Dental Care

Use of Collected Data

-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Performance Measures

NEW HAMPSHIRE

New Hampshire Voluntary Managed Care Program

Process Quality

-Adolescent immunization rate
-Cervical cancer screening rate
-Dental services
-Immunizations for two year olds
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in first 15 months of life

Health Status/Outcomes Quality

-Parent Satisfaction with Dental Care

Access/Availability of Care

None

Use of Services/Utilization

-After-hours visits
-Average number of visits to MH/SUD providers per beneficiary
-Emergency room visits/1,000 beneficiary
-Hospital Days/ 1000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of children at least one initial or periodic screen
-Number of children dental treatment services
-Number of children receiving dental treatment services
-Number of children receiving screening blood lead tests
-Number of children who received well-care screening
-Number of re-admissions,same patients,same diagnosis within 7 days
-Number of receiving any dental services
-Percent of beneficiaries accessing 24-hour day/night care at MH/SUD facility

Health Plan Stability/ Financial/Cost of Care

None

Health Plan/ Provider Characteristics

None

Beneficiary Characteristics

None

Performance Improvement Projects

Project Requirements

-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Non-Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards

None

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-Northeast Health Care Quality Foundation

EQRO Organization

-Quality Improvement Organization (QIO)

EQRO Mandatory Activities

-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities

-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

NEW YORK
Office of Mental Health/Partial Capitation Program

CONTACT INFORMATION

State Medicaid Contact:

Joe Kaiser
New York State Office of Mental Health
(518) 473-9582

State Website Address:

http://www.omh.state.ny.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Mental Health (MH) PAHP - Partial Capitation

Service Delivery

Included Services:
Mental Health Continuion Day Treatment, Mental Health Intensive Psychiatric Rehabilitation Treatment, Mental Health Outpatient

Contractor Types:
-New York State Office of Mental Health Hospital

Allowable PCPs:
-Mental Health PCP
-Personal Services Coordinator

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-Receiving outpatient (Clinic, CDT, IPRT)
-Admitted to an outpatient psychiatric center program

Populations Mandatorily Enrolled:
None

NEW YORK

Office of Mental Health/Partial Capitation Program

Subpopulations Excluded from Otherwise Included Populations:

- -Eligibility Period Less Than 6 Months
- -Participation in HCBS Waiver
- -Special Needs Children (BBA defined)
- -Enrolled in Another Managed Care Program

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- -Surveys medical needs of enrollee to identify members of these groups
- -Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- -Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

OMH/Partial Capitation

ADDITIONAL INFORMATION

The patients are referred by their hospitals or outpatient programs for mental health services. Due to the nature of the program which is for a limited segment of services, the program does not designate a medical primary care provider. Individuals choose their own providers or rely on the contractor for referral. The contractor acts as the gatekeeper.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- -Accreditation for Participation (see below for details)
- -MCO/PIHP/PAHP Standards (see below for details)
- -Performance Measures (see below for details)

Use of Collected Data

- -Contract Standard Compliance
- -Monitor Quality Improvement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Track Health Service provision

Consumer Self-Report Data

None

Use of HEDIS

- -The State DOES NOT use any of the HEDIS measures
- -The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Performance Measures

Process Quality

None

Health Status/Outcomes Quality

None

NEW YORK
Office of Mental Health/Partial Capitation Program

Access/Availability of Care
-Number of encounters per provider

Health Plan Stability/ Financial/Cost of Care
None

Beneficiary Characteristics
None

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Use of acute sector hospitalization

Health Plan/ Provider Characteristics
None

Standards/Accreditation

MCO/PIHP/PAHP Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-Private accreditation organization

Accreditation Required for Participation
-JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

EQRO Name
-Not Applicable

EQRO Mandatory Activities
-Not Applicable

EQRO Optional Activities
None

PENNSYLVANIA
Long Term Care Capitated Assistance Program (PIHP)

CONTACT INFORMATION

State Medicaid Contact:	James Pezzuti PA Department of Publilc Welfare (717) 772-2525
State Website Address:	www.state.pa.us

PROGRAM DATA

Program Service Area:
Zip Code

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
October 01, 1998

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PIHP (non-risk, comprehensive) - Partial Capitation

Service Delivery

Included Services:
Adult Day Care, Case Management, Chiropractic, Dental, Durable Medical Equipment, Hearing, Hospice, Immunization, In-home Supportive Care, Occupational Therapy, Personal Care, Pharmacy, Physical Therapy, Physician, Podiatry, Skilled Nursing Facility, Speech Therapy, Transportation, Vision, X-Ray

Allowable PCPs:
-General Practitioners
-Family Practitioners
-Internists
-Nurse Practitioners
-Physician Assistants

Enrollment

Populations Voluntarily Enrolled:
-Aged and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

PENNSYLVANIA

Long Term Care Capitated Assistance Program (PIHP)

Subpopulations Excluded from Otherwise Included Populations:

- -Reside in Nursing Facility or ICF/MR
- -Enrolled in Another Managed Care Program
- -Participate in HCBS Waiver

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Community - LIFE

LIFE - St. Agnes

LIFE - Pittsburgh

ADDITIONAL INFORMATION

The three pre-PACE sites listed are identified as Medical-only PIHP. The State does not capitate these PIHPs for inpatient hospital services.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- -MCO/PIHP/PAHP Standards (see below for details)
- -Monitoring of MCO/PIHP/PAHP Standards
- -On-Site Reviews

Use of Collected Data

- -Plan Reimbursement
- -Program Evaluation
- -Program Modification, Expansion, or Renewal
- -Regulatory Compliance/Federal Reporting

Consumer Self-Report Data

None

Use of HEDIS

-Not Applicable

Standards/Accreditation

MCO/PIHP/PAHP Standards

-State-Developed/Specified Standards

Accreditation Required for Participation

None

Accreditation for Deeming

None

EQRO Name

-IPRO

EQRO Organization

-State entity

EQRO Mandatory Activities

-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities

-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities

PENNSYLVANIA

Voluntary HMO Contracts

CONTACT INFORMATION

State Medicaid Contact:

Mike Jacobs
Pennsylvania Department of Welfare
(717) 772-6300

State Website Address:

http://www.state.pa.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
January 01, 1972

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, Durable Medical Equipment, Emergency Ambulance Transportation, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility for First 30 Days, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Midwives
-Other Specialists Approved on a Case-by-Case Basis
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations

Populations Mandatorily Enrolled:
None

PENNSYLVANIA
Voluntary HMO Contracts

- Section 1931 (AFDC/TANF) Adults and Related Populations
- Blind/Disabled Adults and Related Populations
- Blind/Disabled Children and Related Populations
- Aged and Related Populations
- State Only Categorically Needy
- State Only Medically Needy
- Pregnant Women
- Special Needs Children (State defined)

Subpopulations Excluded from Otherwise Included Populations:

- State Blind Pension Recipients
- Monthly Spend Downs
- Reside in Nursing Facility or ICF/MR

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

- Asks advocacy groups to identify members of these groups
- Uses eligibility data to identify members of these groups
- Uses enrollment forms to identify members of these groups
- Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

- Aging Agency
- Education Agency
- Housing Agency
- Maternal and Child Health Agency
- Mental Health Agency
- Public Health Agency
- Social Services Agency
- Substance Abuse Agency
- Transportation Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

AmeriHealth HMO, Inc./AmeriHealth Mercy Health Plan - VOL

Gateway Health Plan, Inc. -VOL

Three Rivers Health Plans, Inc./MedPlus - VOL

UPMC Health Plan, Inc./UPMC for You - VOL

ADDITIONAL INFORMATION

Special Needs Children: (state defined) Broadly defined non-categorical to include all children.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

- Consumer Self-Report Data (see below for details)
- Enrollee Hotlines
- Focused Studies
- MCO/PIHP/PAHP Standards (see below for details)
- Monitoring of MCO/PIHP/PAHP Standards
- On-Site Reviews
- Performance Improvements Projects (see below for details)
- Performance Measures (see below for details)

Use of Collected Data

- Beneficiary Plan Selection
- Contract Standard Compliance
- Fraud and Abuse
- Monitor Quality Improvement
- Program Evaluation
- Track Health Service provision

-Provider Data

Consumer Self-Report Data
-CAHPS
  2.0H Adult and Children
-State-developed Survey

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid
-State use/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects

Performance Measures

Process Quality
-Adolescent immunization rate
-Asthma care - medication use
-Breast Cancer screening rate
-Cervical cancer screening rate
-Check-ups after delivery
-Cholesterol screening and management
-Dental services
-Diabetes medication management
-Frequency of on-going prenatal care
-Hearing services for individuals less than 21 years of age
-HIV/AIDS care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit
-Pregnancy Prevention
-Smoking prevention and cessation
-Vision services for individuals less than 21 years of age
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Use of Services/Utilization
-All use of services in HEDIS measures
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per beneficiary
-Number of OB/GYN visits per adult female beneficiary
-Number of PCP visits per beneficiary
-Number of specialist visits per beneficiary
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-Days cash on hand
-Days in unpaid claims/claims outstanding
-Expenditures by medical category of service (I.e., inpatient, ER, pharmacy, lab, x-ray, dental, vision, etc.)
-Medical loss ratio
-Net income
-Net worth
-State minimum reserve requirements
-Total revenue

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)
-Provider turnover

Beneficiary Characteristics
-Information of beneficiary ethnicity/race

-Information on primary languages spoken by beneficiaries
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Percentage of beneficiaries who are auto-assigned to MCOs/PIHPs/PAHPs
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-Multiple, but not all, MCOs/PIHPs/PAHPs participating in the managed care program are required to conduct a common performance improvement project(s) prescribed by the State Medicaid agency.

Non-Clinical Topics

-Availability of language interpretation services

Clinical Topics

None

Standards/Accreditation

MCO/PIHP/PAHP Standards

-CMS's Quality Improvement System for Managed Care (QISMC) Standards for Medicaid and Medicare

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-IPRO

EQRO Mandatory Activities

-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities

-Conduct performance improvement projects
-Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services

PUERTO RICO

Puerto Rico Health Care Plan

CONTACT INFORMATION

State Medicaid Contact:	Enrique Vicens Puerto Rico Health Insurance Administration (787) 474-3300
State Website Address:	http://www.ases.gobierno.pr

PROGRAM DATA

Program Service Area:
Region

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
February 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Case Management, Dental, EPSDT, Family Planning, Hearing, Immunization, Inpatient Hospital, Laboratory, Outpatient Hospital, Pharmacy, Physician, Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Blind/Disabled Adults and Related Populations
-Aged and Related Populations

Populations Mandatorily Enrolled:
None

-Foster Care Children
-TITLE XXI SCHIP
-Individual/Families up to 200% of Puerto Rico poverty level
-Police

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program

Lock-In Provision:

No lock-in

MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:

Case Management, Inpatient Mental Health, Inpatient Substance Use Disorders, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Transportation

Allowable PCPs:

-Psychiatrists
-Psychologists

Enrollment

Populations Voluntarily Enrolled:

-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP
-Foster Care Children
-Individual/families up to 200% of the Puerto Rico poverty line
-Police

Populations Mandatorily Enrolled:

None

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

APS Healthcare
Humana Health Plans of Puerto Rico, Inc.
Triple-S, Inc.
FHC Healthcare
MCS Health Management Options, Inc.

PUERTO RICO

Puerto Rico Health Care Plan

ADDITIONAL INFORMATION

The Puerto Rico Health Insurance Administration (PRHIA) is a public corporation of the government of Puerto Rico established under Act number 72 of September 7, 1993. PRHIA main duty is to obtain health insurance coverage for the medically indigent. Transportation services only include emergency ambulance services. Vision and hearing services only include physician services and other ancillary services. It does not include vision or hearing equipment. Mental Health and Abuse program is separated and handled by MBHOs.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
-Encounter Data (see below for details)
-On-Site Reviews

Consumer Self-Report Data
None

Use of Collected Data
-Program Evaluation

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

Collection: Requirements
-Specifications for the submission of encounter data to the Medicaid agency

Collection: Standardized Forms
None

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Processing
-Date of Payment
-Type of Service
-Diagnosis Codes
-Procedure Codes

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Guidelines for frequency of encounter data submission

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

State conducts general data completeness assessments
Yes

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Quality Improvement Professional Research Organization

EQRO Mandatory Activities
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities

-Validation of client level data, such as claims and encounters

SOUTH CAROLINA
Health Maintenance Organization (HMO)

CONTACT INFORMATION

State Medicaid Contact:

Bruce Harbaugh
Division of Medical Services
(803) 898-2618

State Website Address:

http://www.dhhs.state.sc.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
August 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Alcohol and Drug Screening, Durable Medical Equipment, EPSDT, Hearing, Home Health, Immunization, Inpatient Hospital, Interactive Psychiatric Interview Exam with other mechanisms of communication, Laboratory, Outpatient Hospital, Pharmacy, Physical Exam through the SC Department of Alcohol and other Drug Abuse Services, Physician, Psychiatric Diagnostic Interview Exam, Skilled Nursing Facility, Transportation, X-Ray

Allowable PCPs:
-Rural Health Centers (RHCs)
-Federally Qualified Health Centers (FQHCs)
-Nurse Practitioners
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations

Populations Mandatorily Enrolled:
None

-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Reside in Nursing Facility or ICF/MR
-Participate in HCBS Waiver
-Age 65 Or Older
-Hospice Recipients
-Enrolled In An HMO Through Third Party Coverage

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Select Health of South Carolina, Incorporated

ADDITIONAL INFORMATION

The State does not require the MCO to have accreditation for deeming. However, Select Health, the MCO that State is contracted with has NCQA accreditation. Program provides ambulatory transportation only. MCO is responsible for 4 Mental Health/Alcohol and other drug abuse assessment services as indicated under "Service Delivery" section.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

None

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Monitor Quality Improvement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collection: Standardized Forms
-NSF (National Standard Format)
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Age-appropriate diagnosis/procedure
-Gender-appropriate diagnosis/procedure
-Date of Admission Invalid
-Date of Discharge Invalid
-Dollar amount billed not greater than zero
-Drug Quantity Units not greater than zero
-Invalid Drug Unit Type
-Prescribing Provider Number Not on File
-Submitting Provider Not on File

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. UB-92, NCPDP, ASC X12 837, ADA)
-Guidelines for frequency of encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Specification/source code review, such as a programming language used to create an encounter data file for submission

State conducts general data completeness assessments
Yes

Performance Measures

Process Quality
-Asthma care - medication use
-Check-ups after delivery
-Diabetes medication management
-Frequency of on-going prenatal care
-Immunizations for two year olds
-Initiation of prenatal care - timeliness of
-Lead screening rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Well-child care visit rates in first 15 months of life
-Well-child care visits rates in 3,4,5, and 6 years of life

Access/Availability of Care
-Average distance to PCP
-Average wait time for an appointment with PCP
-Ratio of PCPs to beneficiaries

Health Status/Outcomes Quality
-Patient satisfaction with care
-Percentage of low birth weight infants

Use of Services/Utilization
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Inpatient admissions/1,000 beneficiary

SOUTH CAROLINA
Health Maintenance Organization (HMO)

Health Plan Stability/ Financial/Cost of Care
-Actual reserves held by plan
-State minimum reserve requirements

Beneficiary Characteristics
-Information on primary languages spoken by beneficiaries
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Weeks of pregnancy at time of enrollment in MCO/PIHP/PAHP, for women giving birth during the reporting period

Health Plan/ Provider Characteristics
-Board Certification
-Provider turnover

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
-NCQA (National Committee for Quality Assurance) Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-Carolina Medical Review

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Conduct performance improvement projects
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities
-Validation of client level data, such as claims and encounters

SOUTH CAROLINA
Physicians Enhanced Program (PEP)

CONTACT INFORMATION

State Medicaid Contact:

Marsha Marze
Department of Physician Services
(803) 898-2544

State Website Address:

http://www.dhhs.state.sc.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
May 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Medical-only PAHP (risk, non-comprehensive) - Partial Capitation

Service Delivery

Included Services:
EPSDT, Family Planning, Immunization, Laboratory, Physician, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Nurse Practitioners

Enrollment

Populations Voluntarily Enrolled:
-Foster Care Children
-TITLE XXI SCHIP
-Section 1931 (AFDC/TANF) Children and Related Populations

Populations Mandatorily Enrolled:
None

SOUTH CAROLINA
Physicians Enhanced Program (PEP)

-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Subpopulations Excluded from Otherwise Included Populations:

-Medicare Dual Eligible
-Poverty Level Pregnant Woman
-Reside in Nursing Facility or ICF/MR
-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:

No lock-in

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Education Agency
-Public Health Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Physicians Enhanced Program (PEP)

ADDITIONAL INFORMATION

Only physician services are partially capitated for this program. All other services are fee-for-service.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Not applicable

Consumer Self-Report Data

None

Use of Collected Data

-Not applicable

Use of HEDIS

-Not Applicable

Standards/Accreditation

MCO/PIHP/PAHP Standards

None

Accreditation for Deeming

None

Accreditation Required for Participation

None

EQRO Name

-Not applicable

SOUTH CAROLINA

Physicians Enhanced Program (PEP)

EQRO Organization
-Not applicable

EQRO Mandatory Activities
-Not applicable

EQRO Optional Activities
None

SOUTH DAKOTA
Dental Program

CONTACT INFORMATION

State Medicaid Contact:	Scott Beshara Office of Medical Services (605) 773-3495
State Website Address:	http://www.state.sd.us/social/medicaid

PROGRAM DATA

Program Service Area:
Statewide

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1996

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

Dental PAHP - Full Capitation

Service Delivery

Included Services:
Dental

Allowable PCPs:
-Not Applicable

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Section 1931 (AFDC/TANF) Adults and Related Populations
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations
-Aged and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

SOUTH DAKOTA
Dental Program

Subpopulations Excluded from Otherwise Included Populations:

-No populations are excluded

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-DOES NOT coordinate with any other Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Delta Dental

ADDITIONAL INFORMATION

Most of the Medicaid eligibles are automatically included in the program except beneficiaries with limited benefits.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Encounter Data (see below for details)
-Enrollee Hotlines
-Focused Studies
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

None

Use of Collected Data

-Contract Standard Compliance
-Fraud and Abuse
-Plan Reimbursement
-Program Evaluation
-Program Modification, Expansion, or Renewal
-Regulatory Compliance/Federal Reporting

Use of HEDIS

-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures

Encounter Data

Collection: Requirements

-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-State Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Use of Medicaid Identification Number for beneficiaries

SOUTH DAKOTA
Dental Program

Collection: Standardized Forms
None

Validation: Methods
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
None

State conducts general data completeness assessments
No

Performance Measures

Process Quality
None

Health Status/Outcomes Quality
-Patient satisfaction with care

Access/Availability of Care
-Availability of Dental Providers

Use of Services/Utilization
-Percentage of beneficiaries with at least one dental visit

Health Plan Stability/ Financial/Cost of Care
None

Health Plan/ Provider Characteristics
None

Beneficiary Characteristics
None

Performance Improvement Projects

Project Requirements
-Individual MCOs/PIHPs/PAHPs are required to conduct a project prescribed by the State Medicaid agency

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
None

Accreditation Required for Participation
None

Accreditation for Deeming
None

EQRO Name
-Not Applicable

EQRO Organization
-Not Applicable

EQRO Mandatory Activities
-Does not collect Mandatory EQRO Activities at this time

EQRO Optional Activities
-Not Applicable

WISCONSIN
Children Come First (CCF)

CONTACT INFORMATION

State Medicaid Contact:

Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:

http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
No

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
April 01, 1993

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:
Community Support Program (CSP), Crisis, Emergency Services, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Medical Day Treatment, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

WISCONSIN

Children Come First (CCF)

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-All Enrollees Must Have Special Needs To Be Eligible For Enrollment.
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Community Partnerships
-Dane County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Mental Health Agency
-Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee.
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Dane County Human Services Department -- CCF

ADDITIONAL INFORMATION

Program goal is to keep children with severe emotional disturbances out of institutions and to serve these children and their families in the community. Reallocates previous funding for institutional placement into community based care. Uses a "wraparound," integrated services approach with multi-agency and multi-disciplinary collaboration. Key components include intensive case management, crisis intervention, and a flexible array of services and supports (including some not traditionally covered under Medicaid) based on highly individualized plans of care. This mental health and substance abuse carve-out program does not designate a primary care provider for physical health care.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Use of Collected Data

-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Consumer Self-Report Data

-State-developed Survey

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

WISCONSIN

Children Come First (CCF)

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Collaboration And Teamwork
-Family-Based And Community-Based Service Delivery
-Follow-up after hospitalization for mental illness
-Identification And Process= Service/Care Coordinators (Case Managers)
-Membership And Process= Child And Family Teams (Plan Of Care Teams)
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Process And Content= Plans Of Care
-Process And Content= Service Authorization Plans

Health Status/Outcomes Quality

-Cost-Effectiveness Comparison Of This Managed Care Program To Non-Managed Care
-Criminal Offenses And Juvenile Justice Contracts Of Enrollees, Pre-Test And Post-Test
-Functional Impairment Of Enrollees, Pre-Test And Post-Test
-Patient satisfaction with care
-Restrictiveness Of Living Arrangements For Enrollees, Pre-Test And Post-Test
-School Attendance And Performance Of Enrollees, Pre-Test And Post-Test

Access/Availability of Care

-Internal And External Quality Assurance Audits Of Access And Of Monitoring Plans Of Care

Use of Services/Utilization

-Internal And External Quality Assurance Audits Of Monitoring Plans Of Care And Tracking Actual Service Utilization

Health Plan Stability/ Financial/Cost of Care

None

Health Plan/ Provider Characteristics

-Internal Quality Assurance Review Of Sub-Contracted Providers

Beneficiary Characteristics

-Information of beneficiary ethnicity/race

-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Other Demographic, Clinical, And Service System Characteristics Of Enrollees.

Performance Improvement Projects

Project Requirements

-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics

Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards

-State-Developed/Specified Standards

Accreditation for Deeming

None

EQRO Organization

-Quality Improvement Organization (QIO)

Accreditation Required for Participation

None

EQRO Name

-MetaStar

EQRO Mandatory Activities

-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities

-Quality Of Care Reviews
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities

WISCONSIN

Independent Care Health Plan (iCare)

CONTACT INFORMATION

State Medicaid Contact:

Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address:

http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
Automated Health Systems

For All Areas Phased-In:
No

Guaranteed Eligibility:
No guaranteed eligibility

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
July 01, 1994

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MCO (Comprehensive Benefits) - Full Capitation

Service Delivery

Included Services:
Coordination With Non-Medicaid Services (Social & Vocational Services), Recreational & Wellness Program, Dental, Durable Medical Equipment, EPSDT, Family Planning, Hearing, Home Health, Hospice, Immunization, Inpatient Hospital, Inpatient Mental Health, Inpatient Substance Use Disorders, Laboratory, Outpatient Hospital, Outpatient Mental Health, Outpatient Substance Use Disorders, Pharmacy, Physician, Skilled Nursing Facility, Skilled Nursing Facility Only Covered Up To 90 Days., Transportation, Vision, X-Ray

Allowable PCPs:
-Pediatricians
-General Practitioners
-Family Practitioners
-Internists
-Obstetricians/Gynecologists
-Federally Qualified Health Centers (FQHCs)
-Rural Health Centers (RHCs)
-Indian Health Service (IHS) Providers
-Other Specialists Approved on a Case-by-Case Basis

Enrollment

Populations Voluntarily Enrolled:
-Blind/Disabled Adults and Related Populations
-Blind/Disabled Children and Related Populations

Populations Mandatorily Enrolled:
None

WISCONSIN
Independent Care Health Plan (iCare)

Subpopulations Excluded from Otherwise Included Populations:
- -Beneficiaries Who After Enrollment Are Placed In A Nursing Home For Longer Than 90 Days.
- -Enrolled in Another Managed Care Program
- -Participate in HCBS Waiver
- -Reside in Nursing Facility or ICF/MR
- -Children Under Age 18

Lock-In Provision:
Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs
Yes

Strategies Used to Identify Persons with Complex (Special) Needs:
- -Asks advocacy groups to identify members of these groups
- -Comprehensive Assessment Required At Time of Enrollment
- -Only SSI-Disabled Recipients May Enroll
- -Uses eligibility data to identify members of these groups
- -Uses enrollment forms to identify members of these groups
- -Uses provider referrals to identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:
- -Local Public Health Agency
- -Mental Health Agency
- -Milwaukee County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
- -Substance Abuse Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Independent Care Health Plan (Voluntary, iCare)

ADDITIONAL INFORMATION

Humana/Wisconsin Health Organization (an HMO) and the Milwaukee Center for Independence (a community vocational services agency) were previously partners in a joint venture agreement to operate Independent Care (iCare). Effective June 18, 2003, iCare became an independently licensed HMO and changed its full name to Independent Care Health Plan. Program goals are to integrate medical and social services and to improve quality, access, and coordination of medical services. Reallocates resources to better serve disabled recipients. Care coordinators in addition to PCPs. Initially, iCare was a 3-year research and demonstration grant from CMS. Evaluation was completed in 1998 by an independent firm using interviews, claims data encounter forms, etc.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:
- -Consumer Self-Report Data (see below for details)
- -Encounter Data (see below for details)
- -Enrollee Hotlines
- -MCO/PIHP/PAHP Standards (see below for details)
- -Monitoring of MCO/PIHP/PAHP Standards
- -Ombudsman
- -On-Site Reviews
- -Performance Improvements Projects (see below for details)
- -Performance Measures (see below for details)

Use of Collected Data
- -Contract Standard Compliance
- -Health Services Research
- -Monitor Quality Improvement
- -Program Evaluation
- -Regulatory Compliance/Federal Reporting
- -Track Health Service provision

WISCONSIN
Independent Care Health Plan (iCare)

Consumer Self-Report Data
-CAHPS
  Adult Medicaid SSI Questionnaire
  Adult with Special Needs Questionnaire
-Consumer/Beneficiary Focus Groups
-Disenrollment Survey

Use of HEDIS
-The State uses SOME of the HEDIS measures listed for Medicaid
-The State generates from encounter data SOME of the HEDIS measures listed for Medicaid
-State uses/requires MCOs/PIHPs/PAHPs to follow NCQA specifications for all of the HEDIS measures listed for Medicaid that it collects, BUT modifies the continous enrollment requirement for some or all of the measures
-State modifies/requires MCOs/PIHPs/PAHPs to modify some or all NCQA specifications in ways other than continous enrollment

Encounter Data

Collection: Requirements
-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications
-Data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms
-ADA - American Dental Association dental claim form
-ANSI ASC X12 837 - transaction set format for transmitting health care claims data
-NCPDP - National Council for Prescription Drug Programs pharmacy claim form
-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

Validation: Methods
-Automated analysis of encounter data submission to help determine to data completeness (e.g. frequency distributions, cross-tabulations, trend analysis, etc.)
-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Medical record validation
-Per member per month analysis and comparisons across MCOs/PIHPs/PAHPs

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements
-Date of Service
-Date of Payment
-Provider ID
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes
-Admission Source
-Admission Type
-Days Supply
-Modifier Codes
-Patient Status Code
-Place of Service Codes
-Quantity

State conducts general data completeness assessments
Yes

Performance Measures

WISCONSIN
Independent Care Health Plan (iCare)

Process Quality
-Breast Cancer screening rate
-Cervical cancer screening rate
-Dental services
-Diabetes management/care
-Follow-up after hospitalization for mental illness
-Influenza Vaccination Rate
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Percentage of beneficiaries with at least one dental visit

Access/Availability of Care
-Monitoring Voluntary Disenrollments
-Ratio of mental health providers to number of beneficiaries
-Ratio of PCPs to beneficiaries

Health Plan Stability/ Financial/Cost of Care
None

Beneficiary Characteristics
-Beneficiary need for interpreter
-MCO/PIHP/PAHP/PCP-specific disenrollment rate

Health Status/Outcomes Quality
-Patient satisfaction with care

Use of Services/Utilization
-Average number of visits to MH/SUD providers per beneficiary
-Drug Utilization
-Emergency room visits/1,000 beneficiary
-Hospitalization Rate For Ambulatory Sensitive Conditions
-Inpatient admission for MH/SUD conditions/1,000 beneficiaries
-Inpatient admissions/1,000 beneficiary
-Number of home health visits per beneficiary
-Percentage of beneficiaries with at least one dental visit
-Re-admission rates of MH/SUD

Health Plan/ Provider Characteristics
-Board Certification
-Languages Spoken (other than English)

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-MetaStar

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects
-Validation of performance measures

EQRO Optional Activities
-Calculation of performance measures
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in

conducting quality activities
-Validation of client level data, such as claims and encounters

WISCONSIN

Wraparound Milwaukee

CONTACT INFORMATION

State Medicaid Contact:

Angie Dombrowicki
Bureau of Managed Health Care Programs
(608) 266-1935

State Website Address: http://www.dhfs.state.wi.us

PROGRAM DATA

Program Service Area:
County

Operating Authority:
Voluntary - No Authority

Statutes Utilized:
Not Applicable

Enrollment Broker:
No

For All Areas Phased-In:
Yes

Guaranteed Eligibility:
None

Initial Waiver Approval Date:
Not Applicable

Implementation Date:
March 01, 1997

Waiver Expiration Date:
Not Applicable

Sections of Title XIX Waived:
None

Sections of Title XIX Costs Not Otherwise Matchable Granted:
None

SERVICE DELIVERY

MH/SUD PIHP - Full Capitation

Service Delivery

Included Services:
Community Support Program (CSP), Crisis, Emergency Services, IMD, Inpatient Mental Health, Inpatient Substance Use Disorders, Medical Day Treatment, Mental Health Outpatient, Mental Health Rehabilitation, Mental Health Residential, Mental Health Support, Outpatient Substance Use Disorders, Targeted Case Management

Allowable PCPs:
-Not applicable, contractors not required to identify PCPs

Enrollment

Populations Voluntarily Enrolled:
-Section 1931 (AFDC/TANF) Children and Related Populations
-Foster Care Children
-Blind/Disabled Children and Related Populations
-TITLE XXI SCHIP

Populations Mandatorily Enrolled:
None

WISCONSIN
Wraparound Milwaukee

Subpopulations Excluded from Otherwise Included Populations:

-Enrolled in Another Managed Care Program
-Participate in HCBS Waiver

Lock-In Provision:

Does not apply because State only contracts with one managed care entity

SERVING PEOPLE WITH COMPLEX (SPECIAL) NEEDS

Program Includes People with Complex (Special) Needs

Yes

Strategies Used to Identify Persons with Complex (Special) Needs:

-All Enrollees Must Have Special Needs To Be Eligible For Enrollment.
-DOES NOT identify members of these groups

Agencies with which Medicaid Coordinates the Operation of the Program:

-Mental Health Agency
-Milwaukee County Human Services (Mental Health, Substance Abuse, Social Services, Etc.)
-Other Public And Private Agencies Are On The Statewide Children Come First Advisory Committee
-Social Services Agency

PARTICIPATING PLANS/PCCM AND OTHER PROGRAMS

Milwaukee County Human Services Department --
Wraparound Milwaukee

ADDITIONAL INFORMATION

Program goal is to keep children with severe emotional disturbances out of institutions and to serve these children and their families in the community. Reallocates previous funding for institutional placement into community based care. Uses a "wraparound," integrated services approach with multi-agency and multi-disciplinary collaboration. Key components include intensive case management, crisis intervention, and a flexible array of services and supports (including some not traditionally covered under Medicaid) based on highly individualized plans of care. This mental health and substance abuse carve-out program does not designate a primary care provider for physical health care.

QUALITY ACTIVITIES FOR CAPITATED MANAGED CARE PROGRAMS

State Quality Assessment and Improvement Activities:

-Consumer Self-Report Data (see below for details)
-Encounter Data (see below for details)
-MCO/PIHP/PAHP Standards (see below for details)
-Monitoring of MCO/PIHP/PAHP Standards
-On-Site Reviews
-Performance Improvements Projects (see below for details)
-Performance Measures (see below for details)

Consumer Self-Report Data

-State-developed Survey

Use of Collected Data

-Contract Standard Compliance
-Monitor Quality Improvement
-Program Evaluation
-Regulatory Compliance/Federal Reporting
-Track Health Service provision

Use of HEDIS

-The State DOES NOT use any of the HEDIS measures
-The State DOES NOT generate from encounter data any of the HEDIS measure listed for Medicaid

Encounter Data

WISCONSIN

Wraparound Milwaukee

Collection: Requirements

-Definition(s) of an encounter (including definitions that may have been clarified or revised over time)
-Incentives/sanctions to insure complete, accurate, timely encounter data submission
-Requirements for data validation
-Requirements for MCOs/PIHPs/PAHPs to collect and maintain encounter data
-Specifications for the submission of encounter data to the Medicaid agency
-Standards to ensure complete, accurate, timely encounter data submission

Collections: Submission Specifications

-Deadlines for regular/ongoing encounter data submission(s)
-Encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Guidelines for frequency of encounter data submission
-Guidelines for initial encounter data submission
-Provided data submission requirements including documentation describing set of encounter data elements, definitions, sets of acceptable values, standards for data processing and editing
-Required encounters to be submitted based upon national standardized forms (e.g. NSF, UB-92, NCPDP, ADA)
-Required use of Medicaid Identification Number for beneficiaries

Collection: Standardized Forms

-NSF - (National Standard Format) - the CMS approved electronic flat file format for transmitting non-institutional billing data between trading partners, such as physicians and suppliers
-UB-92 (CMS 1450) - (Uniform Billing) - the CMS approved electronic flat file format for transmitting institutional billing data between trading partners, such as hospitals, long term care facilities,

Validation: Methods

-Automated edits of key fields used for calculation (e.g. codes within an allowable range)
-Specification/source code review, such as a programming language used to create an encounter data file for submission

MCO/PIHP/PAHP conducts data accuracy check(s) on specified data elements

-Date of Service
-Date of Processing
-Date of Payment
-Provider ID
-Type of Service
-Medicaid Eligibility
-Plan Enrollment
-Diagnosis Codes
-Procedure Codes
-Revenue Codes

State conducts general data completeness assessments

Yes

Performance Measures

Process Quality

-Collaboration And Teamwork
-Family-Based And Community-Based Service Delivery
-Follow-up after hospitalization for mental illness
-Identification And Process= Service/Care Coordinators (Case Managers)
-Membership And Process= Child And Family Teams (Plan Of Care Teams)
-Percentage of beneficiaries who are satisfied with their ability to obtain care
-Process And Content= Plans Of Care
-Process And Content= Service Authorization Plans

Health Status/Outcomes Quality

-Cost-Effectiveness Comparison Of This Managed Care Program To Non-Managed Care
-Criminal Offenses And Juvenile Justice Contracts Of Enrollees, Pre-Test And Post-Test
-Functional Impairment Of Enrollees, Pre-Test And Post-Test
-Patient satisfaction with care
-Restrictiveness Of Living Arrangements For Enrollees, Pre-Test And Post-Test
-School Attendance And Performance Of Enrollees, Pre-Test And Post-Test

Access/Availability of Care

-Internal And External Quality Assurance Audits Of Access And Of Monitoring Plans Of Care

Use of Services/Utilization

-Internal And External Quality Assurance Audits Of Monitoring Plans Of Care And Tracking Actual Service Utilization

Health Plan Stability/ Financial/Cost of Care

None

Health Plan/ Provider Characteristics

-Internal Quality Assurance Review Of Sub-Contracted Providers

WISCONSIN
Wraparound Milwaukee

Beneficiary Characteristics
-Information of beneficiary ethnicity/race
-MCO/PIHP/PAHP/PCP-specific disenrollment rate
-Other Demographic, Clinical, And Service System Characteristics Of Enrollees.

Performance Improvement Projects

Project Requirements
-MCOs/PIHPs/PAHPs are required to conduct a project(s) of their own choosing

Non-Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Clinical Topics
Not Applicable - MCOs/PIHPs/PAHPs are not required to conduct common project(s)

Standards/Accreditation

MCO/PIHP/PAHP Standards
-State-Developed/Specified Standards

Accreditation for Deeming
None

EQRO Organization
-Quality Improvement Organization (QIO)

Accreditation Required for Participation
None

EQRO Name
-MetaStar

EQRO Mandatory Activities
-Review of MCO/PIHP/PAHP compliance with structural and operational standards established by the State
-Validation of performance improvement projects

EQRO Optional Activities
-Conduct performance improvement projects
-Quality Of Care Reviews
-Technical assistance to MCOs/PIHPs/PAHPs to assist them in conducting quality activities

Section:
PACE Programs

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CALIFORNIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Louise Nava
Contract Manager
Office of Long Term Care
(916) 440-7538

State Website Address:

http://www.dhs.ca.gov

PACE Organization

Approved PACE Organization Name: AltaMed Health Services Corporation

Program Agreement Effective Date: November 01, 2002

PACE Contact:

Irma Weissenberg
5425 East Pomona Blvd.
Los Angeles CA, 90022
(323) 728-0411

ADDITIONAL INFORMATION

Under the authority of sections 1894 and 1934 of the Social Security Act, PACE organization provide pre-paid, capitated, comprehensive health care services to frail elders.

To be eligible to enroll, individuals must be 55 years of age or older, be determined by the State administering agency to need a nursing facility level of care, and reside in the service of a PACE organization. At the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety. Enrollment is voluntary and is not restricted to individuals who are Medicare beneficiaries and/or Medicaid recipients.

The PACE organization receives a prospective monthly payment for each Medicare participant based on the rate paid to Medicare+Choice and a prospective monthly payment for each Medicaid participant that is negotiated between the PACE organization and the State administering agency. The Medicaid capitation must be less than the amount that would have been paid under the State plan if the individuals were not enrolled in PACE. Pace organization may charge a premium to individuals who do not have Medicaid eligibility.

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COLORADO

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Janet Dauman Program Administrator Dept of Health Care Policy and Financing 303-866-5947
State Website Address:	http://www.CHCPF.state.co.us

PACE Organization

Approved PACE Organization Name:	Total Long Term Care (TLC)
Program Agreement Effective Date:	April 01, 2003
PACE Contact:	David Reyes 200 East 9th Avenue Denver CO, 80203 303-869-4727

ADDITIONAL INFORMATION

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FLORIDA

Program of All-Inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Robert Brown-Barrios Program Administrator AHCA (850)-922-7348
State Website Address:	http://www.fdhc.state.fl.us

PACE Organization

Approved PACE Organization Name:	Florida PACE Centers Inc.
Program Agreement Effective Date:	January 01, 2003
PACE Contact:	Daniel Brady 5200 NE 2nd Avenue Miami FL, 33137 (305)-531-5341

ADDITIONAL INFORMATION

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KANSAS
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Debra Bachmann
Manager, PACE Program
Department of Social and Rehabilitation Services - Health Care
(785) 296-3667

State Website Address:

http://www.srskansas.org

PACE Organization

Approved PACE Organization Name:

Via Christi Healthcare Outreach Program for Elders, Inc. (dba Via Christi HOPE)

Program Agreement Effective Date:

September 01, 2002

PACE Contact:

Gale Remington Smith
935 S. Glendale
Wichita KS, 67208
(316) 858-1111

ADDITIONAL INFORMATION

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MARYLAND

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Katherine Tvaronas Administrator Department of Health and Mental Hygiene 410-767-1478
State Website Address:	http://www.dhmh.state.md.us

PACE Organization

Approved PACE Organization Name:	Hopkins Elder Plus
Program Agreement Effective Date:	November 01, 2002
PACE Contact:	Karen Armacost 4940 Eastern Ave. Baltimore MD, 21224 410-550-5883

ADDITIONAL INFORMATION

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MASSACHUSETTS

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Diane Flanders Director, Coordinated Care Systems Division of Medical Assistance (617) 210-5440
State Website Address:	http://www.state.ma.us

PACE Organization

Approved PACE Organization Name:	Elder Service Plan of Cambridge Health Alliance
Program Agreement Effective Date:	November 01, 2002
PACE Contact:	Pearl White 270 Green Street Cambridge MA, 02139 (617) 868-6323

Approved PACE Organization Name:	Elder Service Plan of Harbor Health Services Inc
Program Agreement Effective Date:	November 01, 2002
PACE Contact:	Rimma Zelfand 2216 Dorchester Avenue Dorchester MA, 02124 (617) 296-5100

Approved PACE Organization Name:	Uphams Elder Service Plan
Program Agreement Effective Date:	November 01, 2002
PACE Contact:	Charlotte Burrage 1140 Dorchester Avenue Dorchester MA, 02125 (617) 288-0970

MASSACHUSETTS
Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Fallon Community Health Plan

Program Agreement Effective Date: November 01, 2002

PACE Contact:
Linda Fitzpatrick
277 East Mountau Street
Worcester MA, 01605
(508) 852-2026

Approved PACE Organization Name: Elder Service Plan of East Boston

Program Agreement Effective Date: November 01, 2003

PACE Contact:
Ginny Felice
10 Gove Street
East Boston MA, 02128
617-568-4575

Approved PACE Organization Name: Elder Service Plan of North Shore

Program Agreement Effective Date: November 01, 2003

PACE Contact:
Carol Suleski
20 School Street
Lynn MA, 01901
781-581-7565

ADDITIONAL INFORMATION

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MISSOURI

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Susan Eggen
MC+ Operations Manager
Department of Social Services, Division of Medical Services
573-751-5178

State Website Address: www.state.mo.us

PACE Organization

Approved PACE Organization Name: Alexian Brothers Community Services

Program Agreement Effective Date: November 01, 2001

PACE Contact:

Deno Fabbre
3900 South Grand
St. Louis MO, 63118
314-771-5800

ADDITIONAL INFORMATION

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NEW YORK

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Linda Gowdy Director, Bureau of Continuing Care Initiatives Office of Managed Care, NYS Dept of Health (518) 478-1141
State Website Address:	www.health.state.ny.us

PACE Organization

Approved PACE Organization Name:	Loretto/Independent Living Services d.b.a. Independent Living Services of Central New York
Program Agreement Effective Date:	November 01, 2002
PACE Contact:	Penny Abulencia 100 Malta Lane North Syracuse NY, 13212 (315) 452-5800
Approved PACE Organization Name:	Senior Care Connection, Inc. d.ba. Eddy Senior Care
Program Agreement Effective Date:	November 01, 2002
PACE Contact:	Bernadette Hallam 504 State Street Schenectady NY, 12305 (518) 382-3290
Approved PACE Organization Name:	Comprehensive Care Management Corporation
Program Agreement Effective Date:	November 01, 2003
PACE Contact:	Susan Aldrich 612 Allerton Avenue Bronx NY, 10457 (718) 515-8600

NEW YORK

Program of All-inclusive Care for the Elderly (PACE)

Approved PACE Organization Name: Independent Living for Seniors, Inc

Program Agreement Effective Date: November 01, 2003

PACE Contact:

Joanne Tallinger
2066 Hudson Ave.
Rochester NY, 14617
(585) 922-2800

ADDITIONAL INFORMATION

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OHIO

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Karen Langer-Gault
Chief
Bureau of Community Access
(614) 644-9209

State Website Address: http://www.state.oh.us/odjfs/index.stm

PACE Organization

Approved PACE Organization Name: Concordia Care

Program Agreement Effective Date: November 01, 2002

PACE Contact:

Janis Faehnrich
2373 Euclid Heights Blvd.
Cleveland Heights OH, 44160
(216) 791-3580

Approved PACE Organization Name: TriHealth SeniorLink

Program Agreement Effective Date: November 01, 2002

PACE Contact:

Brian Tillow
619 Oak Street Winslow Bld. # 216
Cincinnati OH, 45206
(513) 569-6686

ADDITIONAL INFORMATION

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PENNSYLVANIA
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

James Pezzuti
Director, Division of Long Term Care Client Servic
PA Department of Publilc Welfare
(717) 772-2525

State Website Address:

www.state.pa.us

PACE Organization

Approved PACE Organization Name: University of Pennsylvania School of Nursing

Program Agreement Effective Date: January 01, 2002

PACE Contact:

Christine Allen
4101 Woodland Avenue
Philadelphia PA, 19104
(215) 573-7200

ADDITIONAL INFORMATION

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TENNESSEE

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Manny Martins
Deputy Commissioner
TennCare
(615) 741-0213

State Website Address: http://www.state.tn.us/tenncare

PACE Organization

Approved PACE Organization Name: Alexian Brothers Community Services

Program Agreement Effective Date: November 01, 2002

PACE Contact:

Viston Taylor
425 Cumberland Street Suite 110
Chattanooga TN, 37404
(423) 698-0802

ADDITIONAL INFORMATION

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WASHINGTON
Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:

Kristi Knudsen
Program Manager
ADSA
(360) 586-0615

State Website Address: www.dshs.wa.gov

PACE Organization

Approved PACE Organization Name: Providence Elderplace - Seattle

Program Agreement Effective Date: July 27, 2000

PACE Contact:

Ellen Garcia
5900 Martin Luther King Way South
Seattle WA, 98118
(206) 760-6300

ADDITIONAL INFORMATION

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WISCONSIN

Program of All-inclusive Care for the Elderly (PACE)

CONTACT INFORMATION

State Medicaid Contact:	Steven Landkamer Project Manager DHFS/DDES/CDSD (608) 261-7811
State Website Address:	http://www.dhfs.state.wi.us

PACE Organization

Approved PACE Organization Name:	Community Care Organization
Program Agreement Effective Date:	November 01, 2003
PACE Contact:	Paul F. Soczynski 1555 South Layton Boulevard Milwaukee WI, 53215 (414) 902-2363

ADDITIONAL INFORMATION

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National Summary of State Medicaid Managed Care Programs
Glossary as of June 30, 2003

Section: Program Data--Operating Authority Terms

1915(b)(1)	***Service Arrangement provision***. The State may restrict the provider from or through whom beneficiaries may obtain services.
1915(b)(2)	***Locality as Central Broker provision***. Under this provision, localities may assist beneficiaries in selecting a primary care provider.
1915(b)(3)	***Sharing of Cost Savings provision***. The State may share cost savings, in the form of additional services, with beneficiaries.
1915(b)(4)	***Restriction of Beneficiaries to Specified Providers provision***. Under this provision, States may require beneficiaries to obtain services only from specific providers.
1115(a)	***Research and Demonstration Clause***. The State utilizes specific authority within Section 1115(a) of the Social Security Act to allow the State to provide services through the vehicle of a Research and Demonstration Health Care Reform waiver program.
1932(a)	***State Option to use Managed Care.*** This section of the Act permits States to enroll their Medicaid beneficiaries in managed care entities on a mandatory basis without section 1915(b) or 1115 waiver authority.
1902(a)(1)	***Statewideness***. This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. Waiving 1902(a)(1) indicates that this waiver program is not available throughout the State.
1902(a)(10)(B)	***Comparability of Services***. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance. Waiving 1902(a)(10)(B) indicates that the scope of services offered to beneficiaries enrolled in this program are broader than those offered to beneficiaries not enrolled in the program.

1902(a)(23)	***Freedom of Choice***. This section of the Act requires State Medicaid plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted.

Section: Service Delivery--Managed Care Entity Terms

PCCM	***Primary Care Case Management (PCCM) Provider*** is usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category include PCCMs and those PIHPs which act as PCCMs.
PIHP	**Prepaid Inpatient Health Plan (PIHP)** – A PIHP is a prepaid **inpatient** health plan that provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are define in 42 CFR 438.2} There are several types of PIHPs that States use to deliver a range of services. For example, a Mental Health (MH) PIHP is a managed care entity that provides only mental health services.
PAHP	**Prepaid Ambulatory Health Plan (PAHP)** – A PAHP is a prepaid **ambulatory** health plan that provides less than comprehensive services on an at-risk or other than state plan reimbursement basis, and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. {Comprehensive services are defined in 42 CFR 438.2} There are several types of PAHPs that States use to deliver a range of services. For example, a Dental PAHP is a managed care entity that provides only dental services.

MCO	***Managed Care Organization*** is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization, a provider sponsored organization or any other private or public organization which meets the requirements of §1902 (w) to provide comprehensive services.
HIO	***Health Insuring Organization*** is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

Section: Service Delivery--Reimbursement Arrangement Terms

Fee-For-Service	The plan or Primary Care Case Manager is paid for providing services to enrollees solely through fee-for-service payments, plus in most cases, a case management fee.
Full Capitation	The plan or Primary Care Case Manager is paid for providing services to enrollees solely through capitation.
Partial Capitation	The plan or Primary Care Case Manager is paid for providing services to enrollees through a combination of capitation and fee-for-service reimbursements.

Section: Quality Activity Terms

Accreditation for Deeming	Some States use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as "deemed compliance" with a standard.
Accreditation for Participation	State requirement that plans must be accredited to participate in the Medicaid managed care program.
Consumer Self-Report Data	Data collected through survey or focus group. Surveys may include Medicaid beneficiaries currently or previously

	enrolled in a MCO, PIHP, or PAHP. The survey may be conducted by the State or a contractor to the State.
Encounter Data	Detailed data about individual services provided to individual beneficiaries at the point of the beneficiary's interaction with a MCO, PIHP, PAHP institutional or practitioner provider. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims".
Enrollee Hotlines	Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their MCO, PIHP, PAHP. The people who staff hotlines are knowledgeable about program policies and may play an "intake and triage" role or may assist in resolving the problem.
Focused Studies	State required studies that examine a specific aspect of health care (such as prenatal care) for a defined point in time. These projects are usually based on information extracted from medical records or MCO, PIHP, PAHP administrative data such as enrollment files and encounter /claims data. State staff, EQRO staff, MCO, PIHP, PAHP staff or more than one of these entities may perform such studies at the discretion of the State.
MCO/PIHP/PAHP	These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PIHP/PAHP must have in order to participate in the Medicaid program.
Monitoring of Standards	Activities related to the monitoring of standards that have been set for plan structure, operations, and quality improvement/assurance to determine that standards have been established, implemented, adhered to, etc.
Ombudsman	An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PIHP/PAHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PIHP/PAHP, and the provider (as appropriate) to resolve individual enrollee problems.

National Summary of State Medicaid Managed Care Programs
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On-Site Reviews	Reviews performed on-site at the MCO/PIHP/PAHP health care delivery system sites to assess the physical resources and operational practices in place to deliver health care.
Performance Improvement Projects	Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PIHP/PAHPs choosing or prescribed by the State.
Performance Measures	Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PIHP/PAHP.
Provider Data	Data collected through a survey or focus group of providers who participate in the Medicaid program and have provided services to enrolled Medicaid beneficiaries. The State or a contractor of the State may conduct survey.
HEDIS Measures from Encounter Data	*Health Plan Employer Data and Information Set (HEDIS)* measures from encounter data as opposed to having the plans generate HEDIS measures. HEDIS is a collection of performance measures and their definitions produced by the National Committee for Quality Assurance (NCQA).
EQRO	Federal law and regulations require States to use an *External Quality Review Organization (EQRO)* to review the care provided by capitated managed care entities. EQROs may be Quality Improvement Organizations (QIOs), another entity that meets PRO requirements, or a private accreditation body.

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